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RESERVATIONS: 202–523–4538

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Presidential Documents

Title 3—

The President

Presidential Determination No. 2001–09 of January 3, 2001

U.S. Contribution to the Korea Peninsula Energy Development Organization (KEDO): Certification and Waiver Under the Heading ''Nonproliferation, Anti-Terrorism, Demining and Related Programs'' in Title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2001, as Enacted in Public Law 106–429

Memorandum for the Secretary of State

Pursuant to section 572(b) of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 2001, (the ''Act'') (Public Law 106–429), I hereby certify that:

(1) the parties to the Agreed Framework have taken and continue to take demonstrable steps to implement the Joint Declaration on Denuclearization of the Korean Peninsula in which the Government of North Korea has committed not to test, manufacture, produce, receive, possess, store, deploy, or use nuclear weapons, and not to possess nuclear reprocessing or uranium enrichment facilities;

(2) the parties to the Agreed Framework have taken and continue to take demonstrable steps to pursue the North-South dialogue;

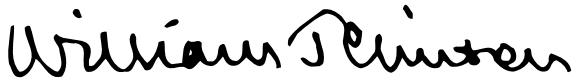
(3) North Korea is complying with all provisions of the Agreed Framework;

(6) North Korea is complying with its commitments regarding access to suspect underground construction at Kumchang-ni; and

(8) the United States is continuing to make significant progress on eliminating the North Korean ballistic missle threat, including further missle tests and its ballistic missle exports.

Pursuant to the authority vested in me by section 572(c) of the Act, I hereby determine that it is vital to the national security interests of the United States to waive the certification requirements of section 572(b) of the Act with respect to paragraphs (4), (5), and (7) of section 572(b) and therefore hereby waive those three certification requirements in order to furnish up to $55 million in funds made available under the heading ''Nonproliferation, Anti-terrorism, Demining and Related Programs'' of the Act, for assistance for KEDO.

You are hereby authorized and directed to report this certification and waiver and the accompanying Memorandum of Justification to the Congress and to arrange for publication of the certification and waiver in the **Federal Register.**



THE WHITE HOUSE,
Washington, January 3, 2001

[FR Doc. 01–1061
Filed 01–10–01; 8:45 am]
Billing code 4710–10–M

Rules and Regulations

Federal Register

Vol. 66, No. 8

Thursday, January 11, 2001

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 AGRICULTURE

Food and Nutrition Service

7 CFR Parts 215, 225, 226, and 245

RIN 0584–AC95

Special Milk Program for Children, Summer Food Service Program, Child and Adult Care Food Program and Determining Eligibility for Free and Reduced Price Meals and Free Milk in Schools: Disclosure of Children's Eligibility Information to State Medicaid and the State Children's Health Insurance Program

AGENCY: Food and Nutrition Service, USDA.

ACTION: Interim rule with request for comments.

SUMMARY: This interim rule amends the regulations for the Special Milk Program for Children, Summer Food Service Program, Child and Adult Care Food Program, and Determining Eligibility for Free and Reduced Price Meals and Milk in Schools. The rule establishes requirements for the disclosure of children's free and reduced price meal or free milk eligibility information to State Medicaid (Medicaid) and the State Children's Health Insurance Program (SCHIP) by State and local agencies responsible for free and reduced price meal or free milk eligibility determinations. These regulations affect State agencies and program operators that administer the Child Nutrition Programs (National School Lunch Program, Special Milk Program for Children, School Breakfast Program, Child and Adult Care Food Program, and the Summer Food Service Program) and who elect to disclose children's free and reduced price meal or free milk eligibility information to Medicaid and SCHIP. The provisions also affect households determined eligible for free and reduced price meals or free milk. The rule reflects the waiver of confidentiality provisions of the Agricultural Risk Protection Act of 2000 and is intended to facilitate enrollment of eligible children in Medicaid and SCHIP.

DATES: *Effective Date:* October 1, 2000. *Comment Date:* To be assured of consideration, comments must be postmarked on or before April 11, 2001.

ADDRESSES: Address all comments concerning this interim rule to Robert M. Eadie, Chief, Policy and Program Development Branch, Child Nutrition Division, Food and Nutrition Service, USDA, 3101 Park Center Drive, Alexandria, VA 22302. You also may submit comments electronically at cndinterim@fns.usda.gov. All written submissions received will be available for public inspection in Room 1007 at the address listed above, during regular business hours (8:30 a.m. to 5:00 p.m.) Monday through Friday.

FOR FURTHER INFORMATION CONTACT: Barbara Semper or Mary Jane Whitney at the above address or by telephone at 703–305–2590. A regulatory cost-benefit analysis was completed for this rule. Single copies may be requested from the FNS officials identified above.

SUPPLEMENTARY INFORMATION:

Background

What Is the Purpose of This Rule?

This interim rule implements a provision of the Agricultural Risk Protection Act of 2000, Public Law (P.L.) 106–224, enacted June 20, 2000. P.L. 106–224 amended section 9(b)(2)(C) of the Richard B. Russell National School Lunch Act (NSLA) (42 U.S.C. 1758(b)(2)(C)) to add Medicaid under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*) and SCHIP under title XXI of that Act (42 U.S.C. 1397aa *et seq.*) to the programs that are authorized limited access to children's free and reduced price meal or free milk eligibility information provided:

(1) The State agency and school food authority elect to disclose children's free and reduced price meal or free milk eligibility information to these health insurance programs;

(2) There is a written agreement between the school and the health insurance program agency that requires the health insurance program agency to use the information to seek to enroll children in Medicaid and SCHIP; and

(3) Parents/guardians are notified and given an opportunity to elect not to have their children's eligibility information disclosed to Medicaid or SCHIP.

Does the NSLA Allow Disclosure of Children's Eligibility Information to Other Programs?

On July 25, 2000, the Food and Nutrition Service (FNS) published a proposed rule on the disclosure of children's (and adult participants' in the Child and Adult Care Food Program) free and reduced price meal or free milk eligibility information (65 FR 45725) to implement provisions of Pub. L. 103–448, the Healthy Meals for Healthy Americans Act of 1994. Pub. L. 103–448 amended the NSLA to allow limited disclosure of children's eligibility information to certain programs and individuals. The comment period for the proposed rule closes on November 22, 2000. In accordance with the statute, the proposed rule would authorize disclosure, without parental/guardian consent, to persons directly connected with the administration or enforcement of:

(1) The NSLA or the Child Nutrition Act of 1966 (CNA) (42 U.S.C. § 1771 *et seq.*) or a regulation issued under either of those Acts;

(2) A Federal education program;

(3) A State health or education program (other than Medicaid) administered by the State or local education agency;

(4) A Federal, State or local means-tested nutrition program with eligibility standards comparable to the National School Lunch Program (NSLP);

(5) The Comptroller General of the United States for audit and examination; and

(6) Certain law enforcement officials for investigating alleged program violations.

Pub. L. 103–448 specifically excluded disclosure of children's eligibility information, without consent, to a program under title XIX of the Social Security Act, i.e., Medicaid (42 U.S.C. 1396 et. seq.). Pub. L. 103–448 did not address disclosure of children's eligibility information to SCHIP, which was established in later Federal legislation. The Agricultural Risk Protection Act of 2000, Pub. L. 106–224, subsequently amended the NSLA to provide disclosure of children's eligibility information to Medicaid and

SCHIP. This interim rule promulgates the regulations for Pub. L. 106–224.

FNS previously issued guidance that allows disclosure of eligibility information consistent with P.L. 103–448. Under that guidance, disclosure to Medicaid and SCHIP is allowed with parental/guardian consent. Please refer to the proposed rule published on July 25, 2000 at 65 FR 45725 for a discussion of the disclosure provisions under P.L. 103–448.

Why Is This Rule Being Issued as an Interim Rule and Not a Proposed Rule?

Section 242(c) of Pub. L. 106–224 makes the provisions of that law addressed in this rulemaking effective October 1, 2000 and section 263 requires that FNS promulgate regulations to implement the provisions as soon as practicable after the date of enactment without regard to the Administrative Procedure Act's notice and comment provisions at 5 U.S.C. § 553; the Statement of Policy of the Secretary of Agriculture effective July 24, 1971 (36 FR 13804) relating to notices of proposed rulemaking and public participation in rulemaking; and the Paperwork Reduction Act at 44 U.S.C. chapter 35. In addition, section 172 of Pub. L. 106–224 requires us to promulgate rules to carry out the Act and its amendments not later than 120 days after the date of enactment. For these reasons, we are not taking public comment prior to promulgation of this interim rule.

To benefit from the experiences of program operators and because the disclosure of eligibility information is a sensitive issue, FNS decided to issue this rule as an interim, rather than a final rule, in order to facilitate public comment. FNS intends to issue a final rule combining the proposed disclosure provisions implementing Pub. L. 103–448 and these interim disclosure provisions implementing Pub. L. 106–224 after consideration of the comments received on these rules.

What Programs Are Being Affected?

As with the amendment to the NSLA made by Pub. L. 103–448, the new provisions pertaining to disclosure of children's eligibility information to Medicaid and SCHIP appear in the part of the NSLA that applies to the free and reduced price meal application process for the NSLP. However, based on FNS practices and policies dealing with past issues and the need for consistency among the Child Nutrition Programs, these regulations on the disclosure of free and reduced price meal or free milk eligibility information by determining agencies to Medicaid and SCHIP apply to all the Child Nutrition Programs—the NSLP, School Breakfast Program (SBP), Special Milk Program for Children (SMP), Child and Adult Care Food Program (CACFP), and camps and enrolled sites in the Summer Food Service Program (SFSP). Therefore, this rule amends the regulations for each of these programs. The various sections amended are listed following the discussion of each issue addressed by this rule. The minor wording differences necessary to accommodate the terminology for the specific programs are not addressed in the preamble. School food authorities, SMP child-care institutions, CACFP institutions, and SFSP sponsors are determining agencies and are collectively referred to as ''program operators'' in the preamble. Additionally, this approach is consistent with the July 25, 2000, proposed rule.

What Definitions Will Be Added to the Regulations?

Disclosure. Any time information is revealed or used for a purpose other than for the purpose for which the information was obtained, it is a disclosure. This is true even when the same agency that obtained the information is the one wishing to use it for another purpose. The term ''disclosure,'' refers to access, release, or transfer of personal data about participants by means of print, tape, microfilm, microfiche, electronic communication or any other means. In this rule, the data would be individual children's free and reduced price eligibility status or other information obtained through the free and reduced price meal or free milk application or through direct certification.

Medicaid and SCHIP. Medicaid and SCHIP refers to the Federal and State funded health insurance programs under titles XIX and XXI of the Social Security Act, which provide free and low cost health insurance to needy children.

This interim rule will include the above definitions in the alphabetical listings at 7 CFR 215.2, 225.2, 226.2, and 245.2.

Is Disclosure of Individual Children's Eligibility Information to Medicaid or SCHIP Required?

Section 9(b)(2)(C)(ii)(IV) of the NSLA, as amended by Pub. L. 106–224, specifies that individual children's eligibility information may be disclosed to Medicaid and SCHIP only if the State agency and program operators ''elect'' to do so. Both the State agency and program operator must agree to the disclosure. Since the disclosure provision applies to all the Child Nutrition Programs, in most cases, this would be the State agency and the school food authority or school, SFSP sponsor, or CACFP institution. This provision is included in §§ 215.13a(g)(1), 225.15(g)(1), 226.23(i)(1), 245.6(f)(1) of this interim rule. Additionally, as discussed later in this preamble, parents/guardians must be given the opportunity to elect not to have their information disclosed.

What Information May Be Disclosed for Use by Medicaid and SCHIP?

When both the State agency and program operators elect to disclose eligibility information for use by Medicaid/SCHIP and parents/guardians have not declined the disclosure, program operators may disclose children's eligibility information. In accordance with section 9(b)(2)(C)(iii)(IV) of the NSLA, program operators may disclose children's names, eligibility status (whether they are eligible for free or reduced price meals or free milk), and any other eligibility information obtained from the application for free and reduced price meals or free milk or through direct certification to persons directly connected with the administration of Medicaid or SCHIP. (Please note that for the Child and Adult Care Food Program and the Summer Food Service Program, children's eligibility information may only be disclosed to the extent that there are free and reduced price meal applications for these children.) This provision is included in §§ 215.13a(g)(2), 225.15(g)(2), 226.23(i)(2), and 245.6(f)(2).

Who Is a Person ''directly connected'' With the Administration of Medicaid or SCHIP?

The NSLA permits disclosure and use of program eligibility information specifically to ''a person directly connected with the administration'' of Medicaid or SCHIP for the purpose of identifying and seeking to enroll children in Medicaid or SCHIP. Persons directly connected with the administration of State Medicaid and SCHIP for purposes of disclosure of free and reduced price meal and free milk eligibility information are State employees and persons authorized under Federal and State Medicaid and SCHIP requirements to carry out initial processing of Medicaid or SCHIP applications or to make eligibility determinations for Medicaid or SCHIP. Initial processing of Medicaid or SCHIP applications includes assisting individuals to fill out the application, explaining requirements and similar

activities. In addition to being authorized under Federal and State Medicaid requirements, persons directly connected with Medicaid or SCHIP administration must be designated by the Medicaid or SCHIP agency to receive Medicaid or SCHIP eligibility information. This may include employees of county health departments, county departments of human or social services, family service agencies or income maintenance agencies. This also may include persons under contract to the State health program to make eligibility determinations and enroll children in the State health insurance program. These entities and persons must have a formal relationship with the Medicaid or SCHIP agency to be directly connected with Medicaid or SCHIP administration.

The statute allows disclosure of children's eligibility information to identify children who may be eligible for one of these health insurance programs and to seek to enroll eligible children in the applicable program. The statute does not authorize disclosure to persons connected with Medicaid or SCHIP enforcement activities. Thus, Federal, State and local reviewers responsible for reviewing or auditing compliance with State Medicaid or SCHIP regulations may not have access to children's free and reduced price meal or free milk eligibility information under this rule.

In general, organizations and individuals assisting in Medicaid and SCHIP outreach activities are not authorized access to children's free and reduced price eligibility information. The intent is to limit disclosure of program eligibility information to those who have a ''need to know'' program eligibility information for identifying and seeking to enroll eligible children in Medicaid and SCHIP. Since States have flexibility in implementing Medicaid and SCHIP, FNS recommends that State agencies and determining agencies contact the Medicaid/SCHIP coordinator in their State to determine the persons or entities authorized and designated by Medicaid or SCHIP to receive eligibility information. A description of ''a person directly connected'' with State Medicaid or SCHIP administration is included in §§ 215.13a(g)(3), 225.15(g)(3), 226.23(i)(3), and 245.6(f)(3) of this rule.

What If Student Records and Other Systems Are Computerized?

FNS is concerned about maintaining the confidentiality of children's eligibility information that is maintained in a computerized data base. Procedures must be in place to ensure that only authorized individuals have access to children's eligibility information.

Many schools are now computerized, and individual student information is often part of a Statewide electronic database under the responsibility of the State's Department of Education. The information may also be part of a local school district database. Typically, these databases contain ''directory information,'' such as student's name, address, phone number, and ''education records,'' such as achievement test scores, grades, special education plans, and evaluations. The Department of Education has regulations restricting access to ''education records,'' including those on computerized systems. These regulations are found at 34 CFR Part 99.

Program operators should take note that ''education records'' do not include Child Nutrition Program eligibility information. Therefore, the Department of Education regulations do not extend to program eligibility information for the Child Nutrition Programs. Nor is compliance with the Department of Education confidentiality regulations sufficient to meet the confidentiality protections in the NSLA. Therefore, program operators, who may also be database managers, must ensure that to the extent that Child Nutrition Program eligibility information is kept together with other school records, controls are established and maintained to ensure that the program eligibility information is available only to authorized persons and used only for authorized purposes.

FNS is not proposing any specific methods to ensure compliance with the NSLA confidentiality provisions in these situations. However, FNS remains concerned about the extent of access to the databases, and ways to protect program eligibility information from disclosure and use beyond what is authorized by Congress. Since FNS experience in this area is limited, commenters are encouraged to provide their experiences with student databases in which access restrictions vary according to the sensitivity of the different data items in the database. An example would be a school district database where access to students' academic records is more restricted than is access to students' class schedules, addresses, and other common information. Comments on this subject will aid FNS in determining whether special controls are necessary in situations in which program eligibility information reside in the same database where other student information is maintained. While this rule would not forbid such arrangement, FNS wishes to emphasize that to comply with this rule, database managers, who may also be program operators, must restrict access to program eligibility information to only those individuals and uses authorized by statute and regulation.

Are There Restrictions on How Children's Free and Reduced Price Eligibility Information May Be Used by State Medicaid and SCHIP?

Section 9(b)(2)(C)(iii)(IV) of the NSLA specifies that Medicaid and SCHIP agencies and health insurance program operators receiving children's free and reduced price meal or free milk eligibility information may only use that information to identify children that may be eligible for State Medicaid or SCHIP and to seek to enroll them in those programs. State agencies and program operators must include this restriction in the agreement with Medicaid or SCHIP officials discussed later in this preamble. This provision is added to § § 215.13a(g)(4), 225.15(g)(4), 226.23(i)(4), and 245.6(f)(4).

The statute and this regulation specify that children's eligibility information, when disclosed to Medicaid or SCHIP, must be used to identify and ''seek to enroll'' children in one of these health insurance programs. In actuality, it is unlikely that children will be automatically enrolled in Medicaid or SCHIP based on information from the free or reduced price application or obtained through direct certification, because Medicaid and SCHIP need additional information to enroll children. Rather, children's free and reduced price meal or free milk eligibility information will be used to facilitate Medicaid and SCHIP enrollment. There is concern that households may believe that by allowing their information to be disclosed to Medicaid and SCHIP, their children will be automatically enrolled in one of these health insurance programs without the household taking further action. Medicaid and SCHIP officials and program operators should work together to ensure that once households are identified as potentially eligible for Medicaid or SCHIP, households are aware that they must complete the Medicaid or SCHIP application process.

Must Households Be Notified of Potential Disclosures to Medicaid and SCHIP?

In accordance with section 9(b)(2)(C)(vi)(II)(aa) and (bb) of the NSLA, for any disclosures to State Medicaid and/or SCHIP, parents/guardians must be notified of the potential disclosure and given the opportunity to elect not to have their

information disclosed. The notification must inform the parents/guardians that: (1) They are not required to consent to the disclosure; (2) the information, if disclosed, will be used to facilitate the identification and enrollment of eligible children in a health insurance program; and (3) their decision will not affect their children's eligibility for free and reduced price meals or free milk. The notification may be included in the letter/notice to parents/guardians that accompanies the free and reduced price meal or free milk application, on the application itself or in a separate but concurrent notice provided to parents/guardians. The notice must be given prior to the disclosure and parents/guardians must be given a reasonable time limit to respond. (A discussion about notifying households of potential disclosures of eligibility information for children who are determined eligible for free meals through direct certification is included below.) Only the parent or guardian who is a member of the household or family for purposes of the free and reduced price meal or free milk application, *i.e.,* the parent/guardian included on the application, must be notified and given the option to decline the disclosure of eligibility information. In most cases of divorce or separation, this means the custodial parent or guardian. However, if custody is shared, the parents or guardians must decide who has primary custody for purposes of making application for the program. The parent or guardian having such custody would be the only person who must be notified and given the option to elect to decline the disclosure. In other words, by not declining to have their information disclosed to Medicaid/SCHIP, the parent/guardian is consenting to have their eligibility information shared. FNS is concerned about the personal financial data at stake. This information is unlike other student records that directly concern the education of the child, and in which both parents have a direct interest. The program eligibility information in these circumstances is associated with one parent or guardian, and FNS believes that only that parent or guardian should be given the option of electing whether or not to disclose their eligibility information. FNS recognizes that this is a difficult issue and is particularly interested in comments on this point.

Regardless of the document used to notify parents/guardians and to secure the consent/declination, officials must provide the household with adequate information for them to determine whether or not to allow the disclosure of their eligibility information. This rule would amend §§ 215.13a(g)(5), 225.15(g)(5), 226.23(i)(5), and 245.6(f)(5) to set the minimum standards for the notice of potential disclosure.

How Are Households Who Are Determined Eligible for Free Meals Through Direct Certification Notified About the Potential Disclosure of Eligibility Information?

Section 9(b)(2)(C)(iii) of the NSLA authorizes the disclosure of participants' free and reduced price information obtained from a free and reduced price meal application or obtained through direct certification. As specified in § 245.6(b), direct certification is the process by which program operators determine program eligibility by directly communicating with the appropriate State or local agency to obtain documentation that an individual is a member of a food stamp household (or member of a household receiving benefits under the Food Distribution Program on Indian Reservations (FDPIR) in lieu of food stamps) or a member of a family receiving assistance under certain State programs for the Temporary Assistance for Needy Families (TANF). In the case of direct certification, the agency administering the Food Stamp Program, FDPIR or TANF, as appropriate, may add a notification/declination statement to the notice of eligibility for free meals or milk under the Child Nutrition Programs that is provided to the household as documentation of eligibility for free meals. The household would be asked to contact the program operator if they did not want their information disclosed to Medicaid or SCHIP. Another option is for the program operator to include the notification/declination statement on the notice of eligibility for free meals that the program operator provides to the households when the direct certification is accomplished by computer match. Regardless of the method chosen to notify households of the potential disclosure and to obtain their consent/declination, officials must provide households with adequate information to determine whether to disclose their information and adequate time for the household to respond.

May Social Security Numbers Be Disclosed?

The Privacy Act of 1974 (5 U.S.C. 552a note) requires that notice be given of the intended uses of social security numbers. Thus, if a State agency or program operator intends to disclose social security numbers, either through the disclosure provisions authorized in the NSLA or with specific parental consent, then section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note) requires that notice of the planned uses of the social security number be given.

The easiest method is to include the planned uses of social security numbers in the Privacy Act notice currently required by §§ 225.15(f)(4)(iv), 226.23(e)(1)(ii)(F), and 245.6(a)(1), because a Privacy Act notice is already on the free and reduced price meal application. The only uses of social security numbers currently listed in the regulations and the prototype application are for the determination and verification of eligibility for program meals. Any State agency or program operator that plans to disclose all eligibility information, including the social security number, to Medicaid or SCHIP administrators or plans to use the number for purposes not specified in their Privacy Act notice must amend the Privacy Act notice to reflect this. State agencies and program operators are responsible for ensuring the adequacy of their Privacy Act notice, and FNS encourages them to consult with their legal counsel. The requirement regarding Privacy Act compliance is specified in §§ 215.13a(g)(6), 225.15(g)(6), 226.23(i)(6), and 245.6(f)(6) of this interim rule.

Currently, the regulations for the SMP do not include a Privacy Act notice. The addition of a Privacy Act notice to the SMP was proposed in the July 25, 2000 rule (65 FR 45725). To ensure Privacy Act compliance in that program, this rule adds a Privacy Act notice requirement for the SMP in child-care institutions. The Privacy Act notice requirement for the SMP in child-care institutions is added at § 215.13a(f).

This rule amends and simplifies current Privacy Act notice required in §§ 226.23(e) and 245.6(a). The revision to the Privacy Act notice on the free and reduced price application replaces the three sentences giving detailed descriptions of the potential use of the social security number for verification with a more general, simpler statement that the social security number will be used in the administration and enforcement of the program. This revision is intended to respond to concerns about the lengthy Privacy Act notice previously required by program regulations. This revision shortens the notice and reduces the amount of space it takes up on the application. An additional Privacy Act notice is required to be given before verification (for those programs subject to verification). That notice would continue to provide the more detailed description on the potential uses of social security numbers in verification. The sections

revised are §§ 225.15(f)(4)(iv), 226.23(e)(1)(ii)(F), and 245.6(a)(1). This revision was proposed in the July 25, 2000 rule (65 FR 45725).

Must There Be an Agreement With State Medicaid and/or SCHIP?

Section 9(b)(2)(C)(vi)(I) of the NSLA specifies that the determining agency must have a written agreement with the State or local agency or agencies administering Medicaid and/or SCHIP prior to disclosing children's free and reduced price meal or free milk eligibility information. At a minimum, the agreement must: (1) Identify the health insurance program or health agency receiving children's eligibility information; (2) describe the information that will be disclosed; (3) require the insurance program or health agency to use the eligibility information obtained; (4) specify that the information must only be used to identify children eligible for and to seek to enroll children in Medicaid or SCHIP; (5) describe how the information will be protected from unauthorized uses and disclosures; (6) describe the penalties for unauthorized disclosure; and (7) be signed by both the determining agency and the Medicaid/SCHIP program or agency receiving children's eligibility information. This provision is included in §§ 215.13a(g)(7), 225.15(g)(7), 226.23(i)(7), and 245.6(f)(7).

What Are the Penalties for Improper Disclosure?

The NSLA establishes a fine of not more than $1000 or imprisonment of not more than 1 year, or both, for publishing, divulging, disclosing, or making known in any manner or extent not authorized by Federal law, any eligibility information. This includes the disclosure of eligibility information by one entity authorized under the statute to receive the information to any other entity, even if that entity would otherwise be authorized to receive the information directly from the determining agency, i.e., third party disclosures are prohibited. These penalties are described in §§ 215.13a(g)(8), 225.15(g)(8), 226.23(i)(8), and 245.6(f)(8) of this interim rule.

What Are the State Agency's Responsibilities?

A State agency that elects to disclose children's free and reduced price meal or free milk information, with the agreement of the determining agency, must ensure that the determining agency: (1) Has a written agreement with the State or local agency or agencies administering health insurance programs for children under title XIX and XXI of the Social Security Act (42 U.S.C. 1396 *et seq.* and 1397aa *et seq.*) that requires the health agencies to use children's free and reduced price meal or free milk eligibility information to seek to enroll children in those health insurance programs; and (2) notifies each household of the information that will be disclosed, that the information disclosed will be used only to seek to enroll children in Medicaid or the State Children's Health Insurance Program and provides each parent/guardian with an opportunity to elect not to have the information disclosed. Sections 215.13a(g)(9), 225.15(g)(9), 226.23(i)(9), and 245.6(f)(9) specify the State agency's responsibilities regarding disclosures.

Summary

FNS is amending the Child Nutrition Program regulations to permit the disclosure of program eligibility information to Medicaid and SCHIP consistent with the recent amendments to the NSLA made by P.L. 106–224. FNS' goal is to facilitate the enrollment of eligible children in those health insurance programs, without sacrificing the confidentiality of children's eligibility information.

Public Participation

Section 242(c) of Pub. L. 106–224 (7 U.S.C. 1421 note) makes the provisions of this rule effective on October 1, 2000. Further, section 263 of Pub. L. 106–224 directs the Department to implement these provisions without regard to the Administrative Procedure Act's notice and public comment provisions at 5 U.S.C. § 553. The Department is thus promulgating the provisions of this interim rule without prior notice or public comment. As a result, as of October 1, program administrators will be given the opportunity to disclose participant's program eligibility information to Medicaid and SCHIP to facilitate enrollment in those programs. The Department, however, is providing interested parties an opportunity to comment on the interim regulatory provisions during the public comment period and will consider comments submitted when finalizing this rule.

Executive Order 12866

This rule has been determined to be significant and was reviewed by the Office of Management and Budget under Executive Order 12866.

Public Law 104–4

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes a requirement for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. Under section 202 of the UMRA, the FNS generally prepares a written statement, including a cost-benefit analysis. This is done for proposed and final rules that have ''Federal mandates'' which may result in expenditures of $100 million or more in any one year by State, local, or tribal governments, in the aggregate, or by the private sector. When this statement is needed for a rule, section 205 of the UMRA generally requires the FNS to identify and consider a reasonable number of regulatory alternatives. It must then adopt the least costly, most cost-effective or least burdensome alternative that achieves the objectives of the rule.

This interim rule contains no Federal mandates of $100 million or more in any one year (under regulatory provisions of Title II of the UMRA) for State, local, and tribal governments or the private sector. Thus, this interim rule is not subject to the requirements of sections 202 and 205 of the UMRA.

Regulatory Flexibility Act

This interim rule has been reviewed with regard to the requirements of the Regulatory Flexibility Act (5 U.S.C. 601–612). Shirley R. Watkins, Under Secretary for Food, Nutrition and Consumer Services, has certified that this rule will not have a significant economic impact on a substantial number of small entities. By permitting access to certain eligibility information, this rule could reduce duplicative paperwork by certain agencies which serve low-income children and adults. The rule could streamline operations of those programs. The provisions of this rule also may enhance access to these programs by needy children. The Department of Agriculture does not anticipate any adverse fiscal impact resulting from implementation of this rulemaking. Although there may be some burdens associated with this rule, the burdens would not be significant and would be outweighed by the benefits of sharing of information.

Executive Order 12372

The Special Milk Program, the Summer Food Service Program, and the Child and Adult Care Food Program are listed in the Catalog of Federal Domestic Assistance under Nos. 10.556, 10.559, and 10.558 respectively. These programs are subject to the provisions of Executive Order 12372, which requires intergovernmental consultation with State and local officials (7 CFR Part

3015, Subpart V, and final rule related notice at 48 FR 29115, June 24, 1983).

Executive Order 12988

This interim rule has been reviewed under Executive Order 12988, Civil Justice Reform. It is intended to have preemptive effect with respect to any State or local laws, regulations or policies which conflict with its provisions or which would impede its full implementation. This rule is not intended to have retroactive effect unless that is specified in the Effective Date section of the preamble of the final rule. Before any judicial challenge to the provisions of this rule or the application of its provisions, all administrative procedures that apply must be followed. The only administrative appeal procedures relevant to this proposed rule are the hearings that FNS must provide for decisions relating to eligibility for free and reduced price meals and free milk (§ 245.7 for the NSLP, SBP, and SMP in schools; § 226.23(e)(5) for the CACFP).

Paperwork Reduction Act

In accordance with the authority provided under section 263 of Pub. L. 106–224, this rulemaking is made without regard to the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35).

This rule contains burdens that were included in the burden estimate in the proposed rule, Disclosure of Children's Eligibility Information, published on July 25, 2000, at 65 FR 45725. That rule proposed to allow the disclosure of children's eligibility information to various education, nutrition, and health programs authorized under Pub. L. 103–448. Additionally, under the proposed rule, officials may disclose children's eligibility to other programs, such as Medicaid and SCHIP, with parental consent.

Since many of the provisions in the proposed rule, mentioned above, and this interim rule are similar, such as taking agreements with persons or agencies receiving children's eligibility information and notifying households of potential disclosures, the Department plans to issue one final rule that responds to commenter concerns on the proposed rule and this interim rule. The Department will make any adjustments to the burden estimate in that final rule.

Federalism Summary Impact Statement

Executive Order 13132 requires Federal agencies to consider the impact of their regulatory actions on State and local governments. Where such actions have ''federalism implications,'' agencies are directed to provide a statement for inclusion in the preamble to the regulation describing the agency's considerations in terms of the three categories called for under section (6)(a)(B) of Executive Order 13132:

Prior Consultation With State Officials

Prior to drafting this interim rule, we received input from State and local agencies at various times. Since the Child Nutrition Programs (CNP) are State administered, federally funded programs, our regional offices have informal and formal discussions with State and local officials on an ongoing basis regarding program implementation and performance. This arrangement allows State and local agencies to provide feedback that forms the basis for any discretionary decisions in this and other CNP rules. The provisions in this rule are primarily non-discretionary. Pub. L. 106–224 mandates that we promptly promulgate regulations without regard to the notice and comment provisions of 5 U.S.C. 553. However, because the disclosure of children's eligibility information is a sensitive issue, we are issuing this rule as an interim rule with a request for public comment.

Nature of Concerns and the Need To Issue This Rule

State and local agencies are generally concerned about protecting the confidentiality of children's eligibility information. They are also concerned about the paperwork and financial burdens placed on food service to provide eligibility information to Medicaid and SCHIP officials.

The issuance of a regulation is required by Pub. L. 106–224. Prior to Pub. L. 106–224, program officials were permitted to disclose children's eligibility information to certain programs and individuals without parental consent. Medicaid and SCHIP were not included. Therefore, program officials had to obtain the consent of parents/guardians if they elected to disclose children's eligibility information with Medicaid and SCHIP. A proposed rule to allow the disclosure of eligibility information to these other programs was published on July 25, 2000 (64 FR 45725). In accordance with Pub. L. 106–224, this interim rule will allow the disclosure of children's eligibility information unless parents/guardian elect not to have their information disclosed to Medicaid and SCHIP. Certain other provisions, as specified in the statute, must also be met prior to disclosing information to Medicaid and SCHIP.

Extent to Which We Meet These Concerns

We believe that we adequately address the issue of State and local flexibility. We clarify that the disclosure of children's eligibility information to Medicaid is a State and local decision. They are not required to disclose children's eligibility information. However, we encourage State and local agencies to work with Medicaid and SCHIP officials to make the exchange of eligibility information as streamlined as possible. Additionally, FNS has issued prototype materials, such as a prototype agreement between program operators and an agency receiving eligibility information and a prototype notification to parents/guardians that their eligibility information may be disclosed unless the program operator is notified that they do not want their information disclosed. Additionally, the Department of Health and Human Services, the department that administers Medicaid and SCHIP, is preparing an administrative guidance on reimbursement for costs associated with Medicaid and SCHIP outreach and enrollment. Finally, we will consider all comments received on this rule when we draft the final rule.

List of Subjects

7 CFR Part 215

Food assistance programs, Grant programs-education, Grant programs-health, Infants and children, Milk, Reporting and recordkeeping requirements.

7 CFR Part 225

Food assistance programs, Grant programs-health, Infants and children, Labeling, Reporting and recordkeeping requirements.

7 CFR Part 226

Accounting, Aged, Day care, Food assistance programs, Grant programs, Grant programs-health, Indians, Individuals with disabilities, Infants and children, Intergovernmental relations, Loan programs, Reporting and recordkeeping requirements, Surplus agricultural commodities.

7 CFR Part 245

Civil rights, Food assistance programs, Grant programs-education, Grant programs-health, Infants and children, Milk, Reporting and recordkeeping requirements, School breakfast and lunch programs.

Accordingly, 7 CFR Parts 215, 225, 226, and 245 are amended as follows:

PART 215—SPECIAL MILK PROGRAM FOR CHILDREN

1. Revise the authority citation for Part 215 to read as follows:

Authority: 42 U.S.C. 1772 and 1779.

2. In § 215.2:

a. Add a new paragraph (i–l) *Disclosure*;

b. Add a new paragraph (k–l) *Medicaid*; and

c. Redesignate paragraph (aa) *Summer Food Service Program* as paragraph (bb) *Summer Food Service Program* and add a new paragraph (aa) *State Children's Health Insurance Program* in its place.

The additions read as follows:

§ 215.2 Definitions.

* * * * *

(i–1) *Disclosure* means individual children's program eligibility information obtained through the free milk eligibility process that is revealed or used for a purpose other than for the purpose for which the information was obtained. The term refers to access, release, or transfer of personal data about children by means of print, tape, microfilm, microfiche, electronic communication or any other means.

* * * * *

(k–1) *Medicaid* means the State medical assistance program under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*).

* * * * *

(aa) *State Children's Health Insurance Program (SCHIP)* means the State medical assistance program under title XXI of the Social Security Act (42 U.S.C. 1397aa *et seq.*).

* * * * *

3. In § 215.13a, add new paragraphs (f) and (g) to read as follows:

§ 215.13a Determining eligibility for free milk in child-care institutions.

* * * * *

(f) *Is a Privacy Act notice required on the free milk application?* Each free milk application must include substantially the following statement: ''Unless you include your child's case number for the Food Stamp Program, the Food Distribution Program on Indian Reservations (or other identifier for the Food Distribution Program on Indian Reservations) or the Temporary Assistance for Needy Families Program, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. This is required by section 9 of the National School Lunch Act. The social security number is not mandatory, but the application cannot be approved if a social security number is not given or an indication is not made that the signer does not have a social security number. The social security number will be used in the administration and enforcement of the program.''

(g) *Disclosure of program eligibility information to State Medicaid (Medicaid) and the State Children's Health Insurance Program (SCHIP)* Program eligibility information about children eligible for free milk may be disclosed to Medicaid and SCHIP as described in this section.

(1) *Who decides whether to disclose program eligibility information to Medicaid and/or SCHIP?* The State agency may elect to allow child care institutions to disclose children's free milk eligibility information to Medicaid and SCHIP. Child care institutions may then elect to do so. Children's program eligibility information may only be disclosed to Medicaid or SCHIP when both the State agency and the child care institution so elect, the parent/guardian does not decline to have their eligibility information disclosed as described in paragraph (g)(5), and the requirements in this paragraph (g) are met.

(2) *What information may we disclose for use by Medicaid and SCHIP?* The State agency or child care institution, as appropriate, may disclose children's names, eligibility status (whether they are eligible for free milk), and any other eligibility information obtained through the free milk application or obtained through direct certification to persons directly connected with the administration of Medicaid or SCHIP.

(3) *Who are persons ''directly connected'' with the administration of Medicaid and SCHIP?* State employees and persons authorized under Federal and State Medicaid and SCHIP requirements to carry out initial processing of Medicaid or SCHIP applications or to make eligibility determinations are persons directly connected with the administration of Medicaid and SCHIP for purposes of disclosure of children's free milk eligibility information.

(4) *What are the restrictions on how Medicaid and SCHIP use children's free milk eligibility information?* Medicaid and SCHIP agencies and health insurance program operators receiving children's free milk eligibility information may only use the information to seek to enroll children in Medicaid or SCHIP. The Medicaid and SCHIP enrollment process may include targeting and identifying children from low-income households who are potentially eligible for Medicaid or SCHIP for the purpose of seeking to enroll them in Medicaid or SCHIP.

(5) *Must we notify households of potential disclosure to Medicaid or SCHIP?* The State agency or child care institution, as appropriate, must notify parents/guardians that their children's free milk eligibility information will be disclosed to Medicaid and/or SCHIP unless the parent/guardian elects not to have their information disclosed. Additionally, the State agency or sponsor, as appropriate, must give parents/guardians an opportunity to elect not to have their information disclosed to Medicaid or SCHIP. Only the parent or guardian who is a member of the household or family for purposes of the free and reduced price meal or free milk application may decline the disclosure of eligibility information. The notification must inform parents/guardians that they are not required to consent to the disclosure, that the information, if disclosed, will be used to identify children eligible for and to seek to enroll children in a health insurance program, and that their decision will not affect their children's eligibility for free milk. The notification may be included in the letter/notice to parents/guardians that accompanies the free milk application, on the application itself or in a separate notice provided to parents/guardians. The notice must give parents/guardians adequate time to respond. For children determined eligible through direct certification, the notice of potential disclosure may be included in the document informing parents/guardians of their children's eligibility for free milk through direct certification.

(6) *May social security numbers be disclosed?* The State agency or child care institution, as appropriate, may disclose social security numbers to any programs or persons authorized to receive all program eligibility information under this paragraph (g), provided parents/guardians have not declined to have their information disclosed. However State agencies and child care institutions that plan to disclose social security numbers must give notice of the planned use of the social security numbers. This notice must be in accordance with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note). The application must include substantially the following language for disclosures of social security numbers to Medicaid or SCHIP: ''The social security number may also be disclosed to Medicaid and the State Children's Health Insurance Program for the purpose of identifying and seeking to enroll eligible children in one of these health insurance programs.'' This

language is in addition to the notice required in paragraph (f) of this section. State agencies and child care institutions are responsible for drafting the appropriate notice for disclosures of social security numbers.

(7) *Are agreements required before disclosing program eligibility information?* The State agency or child care institution, as appropriate, must have a written agreement with the State or local agency or agencies administering Medicaid or SCHIP prior to disclosing children's free milk eligibility information. At a minimum, the agreement must:

(i) Identify the health insurance program or health agency receiving children's eligibility information;

(ii) Describe the information that will be disclosed;

(iii) Require that the Medicaid or SCHIP agency use the information obtained and specify that the information must only be used to seek to enroll children in Medicaid or SCHIP;

(iv) Describe how the information will be protected from unauthorized uses and disclosures;

(v) Describe the penalties for unauthorized disclosure; and

(vi) Be signed by both the Medicaid or SCHIP program or agency and the State agency or child care institution, as appropriate.

(8) *What are the penalties for unauthorized disclosure or misuse of information?* In accordance with section 9(b)(2)(C)(v) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(C)(v)), any individual who publishes, divulges, discloses or makes known in any manner, or to any extent not authorized by statute or this section, any information obtained under this paragraph (g) will be fined not more than $1,000 or imprisoned for up to 1 year, or both.

(9) *What are the State agency's responsibilities regarding disclosures?* State agencies that elect to allow disclosure of children's free milk eligibility information to Medicaid or SCHIP, as provided in this paragraph (g), must ensure that any child care institution acting in accordance with that option:

(i) Has a written agreement with the State or local agency or agencies administering health insurance programs for children under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq. and 1397aa et seq.) that requires the health agencies to use children's free milk eligibility information to seek to enroll children in those health insurance programs; and

(ii) Notifies each household of the information that will be disclosed, that the information disclosed will be used only to seek to enroll children in Medicaid or SCHIP and provides each parent/guardian with an opportunity to elect not to have the information disclosed.

PART 225—SUMMER FOOD SERVICE PROGRAM

1. The authority citation for Part 225 continues to read as follows:

Authority: Secs. 9, 13, and 14, National School Lunch Act, as amended (42 U.S.C. 1758, 1761, and 1762a).

2. In § 225.2, add new paragraphs *Disclosure; Medicaid;* and *State Children's Health Insurance Program (SCHIP)* in alphabetical order to read as follows:

§ 225.2 Definitions.

* * * * *

Disclosure means individual children's program eligibility information obtained through the free and reduced price meal eligibility process that is revealed or used for a purpose other than for the purpose for which the information was obtained. The term refers to access, release, or transfer of personal data about children by means of print, tape, microfilm, microfiche, electronic communication or any other means.

* * * * *

Medicaid means the State medical assistance program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

* * * * *

State Children's Health Insurance Program (SCHIP) means the State medical assistance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

* * * * *

3. In § 225.15:

a. Revise paragraph (f)(4)(iv), and

b. Redesignate paragraphs (g) and (h) as paragraphs (h) and (i) and add a new paragraph (g).

The revision and addition reads as follows:

§ 225.15 Management responsibilities of sponsors.

* * * * *

(f) * * *

(4) * * *

(iv) The following statement that provides notice to the household member whose social security number is disclosed: ''Unless you include your child's case number for the Food Stamp Program, the Food Distribution Program on Indian Reservations (or other identifier for the Food Distribution Program on Indian Reservations) or the Temporary Assistance for Needy Families Program, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. This is required by section 9 of the National School Lunch Act. The social security number is not mandatory, but the application cannot be approved if a social security number is not given or an indication is not made that the signer does not have a social security number. The social security number will be used in the administration and enforcement of the program.''

* * * * *

(g) *Disclosure of program eligibility information to State Medicaid (Medicaid) and the State Children's Health Insurance Program (SCHIP).* Program eligibility information about children eligible for free and reduced price meals may be disclosed to Medicaid and SCHIP as described in this section.

(1) *Who decides whether to disclose program eligibility information to Medicaid and/or SCHIP?* The State agency may elect to allow sponsors to disclose children's free and reduced price meal eligibility information to Medicaid and SCHIP. Sponsors may then elect to do so. Children's program eligibility information may only be disclosed to Medicaid or SCHIP when both the State agency and the sponsor so elect, the parent/guardian does not decline to have their eligibility information disclosed as described in paragraph (g)(5), and the requirements in this paragraph (g) are met. y

(2) *What information may we disclose for use by Medicaid and SCHIP?* The State agency or sponsor, as appropriate, may disclose children's names, eligibility status (whether they are eligible for free or reduced price meals), and any other eligibility information obtained through the free and reduced price meal application or obtained through direct certification to persons directly connected with the administration of Medicaid or SCHIP.

(3) *Who are persons ''directly connected'' with the administration of Medicaid and SCHIP?* State employees and persons authorized under Federal and State Medicaid and SCHIP requirements to carry out initial processing of Medicaid or SCHIP applications or to make eligibility determinations are persons directly connected with the administration of Medicaid and SCHIP for purposes of disclosure of children's free and

reduced price meal eligibility information.

(4) *What are the restrictions on how Medicaid and SCHIP use children's free and reduced price meal eligibility information?* Medicaid and SCHIP agencies and health insurance program operators receiving children's free and reduced price meal eligibility information may only use the information to enroll children in Medicaid or SCHIP. The Medicaid and SCHIP enrollment process may include targeting and identifying children from low-income households who are potentially eligible for Medicaid or SCHIP for the purpose of seeking to enroll them in Medicaid or SCHIP.

(5) *What are the requirements for notifying households of potential disclosure to Medicaid or SCHIP?* The State agency or sponsor, as appropriate, must notify parents/guardians that their children's free or reduced price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless the parent/guardian elects not to have their information disclosed. Additionally, the State agency or sponsor, as appropriate, must give parents/guardians an opportunity to elect not to have their information disclosed to Medicaid or SCHIP. Only the parent or guardian who is a member of the household or family for purposes of the free and reduced price meal or free milk application may decline the disclosure of eligibility information. The notification must inform parents/guardians that they are not required to consent to the disclosure, that the information, if disclosed, will be used to identify children eligible for and seek to enroll children in a health insurance program, and that their decision will not affect their children's eligibility for free or reduced price meals. The notification may be included in the letter/notice to parents/guardians that accompanies the free and reduced price application, on the application itself or in a separate notice provided to parents/guardians. The notice must give parents/guardians adequate time to respond. For children determined eligible through direct certification, the notice of potential disclosure may be included in the document informing parents/guardians of their children's eligibility for free meals through direct certification.

(6) *May social security numbers be disclosed?* The State agency or sponsor, as appropriate, may disclose social security numbers to any programs or persons authorized to receive all program eligibility information under this paragraph (g), provided parents/guardians have not declined to have their information disclosed. However, State agencies and sponsors that plan to disclose social security numbers must give notice of the planned use of the social security number. This notice must be in accordance with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note). The application must include substantially the following language for disclosures of social security numbers to Medicaid or SCHIP: ''The social security number may also be disclosed to Medicaid and the State Children's Health Insurance Program for the purpose of identifying and seeking to enroll eligible children in one of these health insurance programs.'' This language is in addition to the notice required in paragraph (f)(4)(iv) of this section. State agencies and sponsors are responsible for drafting the appropriate notice for disclosures of social security numbers.

(7) *Are agreements required before disclosing program eligibility information?* The State agency or sponsor, as appropriate, must have a written agreement with the State or local agency or agencies administering Medicaid or SCHIP prior to disclosing children's free and reduced price eligibility information. At a minimum, the agreement must:

(i) Identify the health insurance program or health agency receiving children's eligibility information;

(ii) Describe the information that will be disclosed;

(iii) Require that the Medicaid or SCHIP agency use the information obtained and specify that the information must only be used to seek to enroll children in Medicaid or SCHIP;

(iv) Describe how the information will be protected from unauthorized uses and disclosures;

(v) Describe the penalties for unauthorized disclosure; and

(vi) Be signed by both the Medicaid or SCHIP program or agency and the State agency or sponsor, as appropriate.

(8) *What are the penalties for unauthorized disclosure or misuse of information?* In accordance with section 9(b)(2)(C)(v) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(C)(v)), any individual who publishes, divulges, discloses or makes known in any manner, or to any extent not authorized by statute or this section, any information obtained under this paragraph (g) will be fined not more than $1,000 or imprisoned for up to 1 year, or both.

(9) *What are the State agency's responsibilities regarding disclosures?* State agencies that elect to allow disclosure of children's free and reduced price meal eligibility information to Medicaid or SCHIP, as provided in this paragraph (g), must ensure that any sponsor acting in accordance with that option:

(i) Has a written agreement with the State or local agency or agencies administering health insurance programs for children under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 *et seq.* and 1397aa *et seq.*) that requires the health agencies to use children's free and reduced price meal eligibility information to seek to enroll children in those health insurance programs; and

(ii) Notifies each household of the information that will be disclosed, that the information disclosed will be used only to seek to enroll children in Medicaid or SCHIP and provides each parent/guardian with an opportunity to elect not to have the information disclosed.

* * * * *

PART 226—CHILD AND ADULT CARE FOOD PROGRAM

1. The authority citation for Part 226 continues to read as follows:

Authority: Secs. 9, 11, 14, 16 and 17, National School Lunch Act, as amended (42 U.S.C. 1758, 1759a, 1762a, 1765, and 1766).

2. In § 226.2, add new paragraphs *Disclosure; Medicaid;* and *State Children's Health Insurance Program (SCHIP)* in alphabetical order to read as follows:

§ 226.2 Definitions.

* * * * *

Disclosure means individual children's program eligibility information obtained through the free and reduced price meal eligibility process that is revealed or used for a purpose other than for the purpose for which the information was obtained. The term refers to access, release, or transfer of personal data about children by means of print, tape, microfilm, microfiche, electronic communication or any other means.

* * * * *

Medicaid means *Title XIX* of the Social Security Act.

* * * * *

State Children's Health Insurance Program (SCHIP) means the State medical assistance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.).

* * * * *

3. In § 226.23, revise paragraph (e)(1)(ii)(F) and add a new paragraph (i) to read as follows:

§ 226.23 Free and reduced-price meals.

* * * * *

(e)(1) * * *

(ii) * * *

(F) A statement that includes substantially the following information: ''Unless you include your child's case number for the Food Stamp Program, the Food Distribution Program on Indian Reservations (or other identifier for the Food Distribution Program on Indian Reservations) or the Temporary Assistance for Needy Families Program, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. This is required by section 9 of the National School Lunch Act. The social security number is not mandatory, but the application cannot be approved if a social security number is not given or an indication is not made that the signer does not have a social security number. The social security number will be used in the administration and enforcement of the program.'' State agencies and institutions must ensure that the notice complies with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note); and

* * * * *

(i) *Disclosure of program eligibility information to State Medicaid (Medicaid) and the State Children's Health Insurance Program (SCHIP)* Program eligibility information about children eligible for free and reduced price meals may be disclosed to Medicaid and SCHIP as described in this section.

(1) *Who decides whether to disclose program eligibility information to Medicaid and/or SCHIP?* The State agency may elect to allow institutions to disclose children's free and reduced price meal eligibility information to Medicaid and SCHIP. Institutions may then elect to do so. Children's program eligibility information may only be disclosed to Medicaid or SCHIP when both the State agency and the institution so elect, the parent/guardian does not decline to have their eligibility information disclosed as described in paragraph (i)(5), and the requirements in this paragraph (i) are met.

(2) *What information may we disclose for use by Medicaid and SCHIP?* The State agency or institution, as appropriate, may disclose children's names, eligibility status (whether they are eligible for free or reduced price meals), and any other eligibility information obtained through the free and reduced price meal application to persons directly connected with the administration of Medicaid or SCHIP.

(3) *Who are persons ''directly connected'' with the administration of Medicaid and SCHIP?* State employees and persons authorized under Federal and State Medicaid and SCHIP requirements to carry out initial processing of Medicaid or SCHIP applications or to make eligibility determinations are persons directly connected with the administration of Medicaid and SCHIP for purposes of disclosure of children's free and reduced price meal eligibility information.

(4) *What are the restrictions on how Medicaid and SCHIP use children's free and reduced price meal eligibility information?* Medicaid and SCHIP agencies and health insurance program operators receiving children's free and reduced price meal eligibility information may only use the information to seek to enroll children in Medicaid or SCHIP. The Medicaid and SCHIP enrollment process may include targeting and identifying children from low-income households who are potentially eligible for Medicaid or SCHIP for the purpose of seeking to enroll them in Medicaid or SCHIP.

(5) *What are the requirements for notifying households of potential disclosure to Medicaid or SCHIP?* The State agency or institution, as appropriate, must notify parents/guardians that children's free or reduced price meal eligibility information will be disclosed to Medicaid and/or SCHIP unless the parent/guardian elects not to have their information disclosed. Additionally, the State agency or institution, as appropriate, must give parents/guardians an opportunity to elect not to have their information disclosed to Medicaid or SCHIP. Only the parent or guardian who is a member of the household or family for purposes of the free and reduced price meal or free milk application may decline the disclosure of eligibility information. The notification must inform parents/guardians that they are not required to consent to the disclosure, that the information, if disclosed, will be used to identify children eligible for and to seek to enroll children in a health insurance program, and that their decision will not affect their children's eligibility for free or reduced price meals. The notification may be included in the letter/notice to parents/guardians that accompanies the free and reduced price application, on the application itself or in a separate notice provided to parents/guardians. The notice must give parents/guardians adequate time to respond. For children determined eligible through direct certification, the notice of potential disclosure may be included in the document informing parents/guardians of their children's eligibility for free meals through direct certification.

(6) *May social security numbers be disclosed?* The State agency or institution, as appropriate, may disclose social security numbers to any programs or persons authorized to receive all program eligibility information under this paragraph (i), provided parents/guardians have not declined to have their information disclosed. However, State agencies and institutions that plan to disclose social security numbers must give notice of the planned use of the social security numbers. This notice must be in accordance with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note). The application must include substantially the following language for disclosures of social security numbers to Medicaid or SCHIP: ''The social security number may also be disclosed to Medicaid and the State Children's Health Insurance Program for the purpose of identifying and seeking to enroll eligible children in one of these health insurance programs.'' This language is in addition to the notice required in paragraph (e)(1)(i)(F) of this section. State agencies and institutions are responsible for drafting the appropriate notice for disclosures of social security numbers.

(7) *Are agreements required before disclosing program eligibility information?* The State agency or institution, as appropriate, must have a written agreement with the State or local agency or agencies administering Medicaid or SCHIP prior to disclosing children's free and reduced price eligibility information. At a minimum, the agreement must:

(i) Identify the health insurance program or health agency receiving children's eligibility information;

(ii) Describe the information that will be disclosed;

(iii) Require that the Medicaid or SCHIP agency use the information obtained and specify that the information must only be used to seek to enroll children in Medicaid or SCHIP;

(iv) Describe how the information will be protected from unauthorized uses and disclosures;

(v) Describe the penalties for unauthorized disclosure; and

(vi) Be signed by both the Medicaid or SCHIP program or agency and the State agency or institution, as appropriate.

(8) *What are the penalties for unauthorized disclosure or misuse of information?* In accordance with section 9(b)(2)(C)(v) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(C)(v)), any individual who publishes, divulges, discloses or makes known in any manner, or to any extent

not authorized by statute or this section, any information obtained under this paragraph (i) will be fined not more than $1,000 or imprisoned for up to 1 year, or both.

(9) *What are the State agency's responsibilities regarding disclosures?* State agencies that elect to allow disclosure of children's free and reduced price meal eligibility information to Medicaid or SCHIP, as provided in this paragraph (i), must ensure that any institution acting in accordance with that option:

(i) Has a written agreement with the State or local agency or agencies administering health insurance programs for children under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 *et seq.* and 1397aa *et seq.*) that requires the health agencies to use children's free and reduced price meal eligibility information to seek to enroll children in those health insurance programs; and

(ii) Notifies each household of the information that will be disclosed, that the information disclosed will be used only to seek to enroll children in Medicaid or SCHIP and provides each parent/guardian with an opportunity to elect not to have the information disclosed.

PART 245—DETERMINING ELIGIBILITY FOR FREE AND REDUCED PRICE MEALS AND FREE MILK IN SCHOOLS

1. The authority citation for Part 245 is revised to read as follows:

Authority: 42 U.S.C. 1752, 1758, 1759a, 1772, 1773, and 1779.

2. In § 245.2:

a. Redesignate paragraph (a–3) as paragraph (a–4) and add new paragraph (a–3) in its place;

b. Redesignate paragraph (f–1) as paragraph (f–2) and add a new paragraph (f–1) in its place; and

c. Redesignate paragraphs (k) and (l) as paragraphs (l) and (m) and add a new paragraph (k).

The additions read as follows:

§ 245.2 Definitions.

* * * * *

(a–3) *Disclosure* means individual children's program eligibility information obtained through the free and reduced price meal or free milk eligibility process that is revealed or used for a purpose other than for the purpose for which the information was obtained. The term refers to access, release, or transfer of personal data about children by means of print, tape, microfilm, microfiche, electronic communication or any other means.

* * * * *

(f–1) *Medicaid* means the State medical assistance program under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*).

* * * * *

(k) *State Children's Health Insurance Program (SCHIP)* means the State medical assistance program under title XXI of the Social Security Act (42 U.S.C. 1397aa *et seq.*).

* * * * *

3. In § 245.6, revise paragraph (a)(1) and add a new paragraph (f) to read as follows:

§ 245.6 Certification of children for free and reduced price meals and free milk.

(a) * * *

(1) ''Unless you include your child's case number for the Food Stamp Program, the Food Distribution Program on Indian Reservations (or other identifier for the Food Distribution Program on Indian Reservations) or the Temporary Assistance for Needy Families Program, you must include the social security number of the adult household member signing the application or indicate that the household member does not have a social security number. This is required by section 9 of the National School Lunch Act. The social security number is not mandatory, but the application cannot be approved if a social security number is not given or an indication is not made that the signer does not have a social security number. The social security number will be used in the administration and enforcement of the program.'' State agencies and school food authorities must ensure that the notice complies with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note); and

* * * * *

(f) *Disclosure of program eligibility information to State Medicaid (Medicaid) and the State Children's Health Insurance Program (SCHIP)* Program eligibility information about children eligible for free and reduced price meals may be disclosed to Medicaid and SCHIP as described in this section.

(1) *Who decides whether to disclose program eligibility information to Medicaid and/or SCHIP?* The State agency may elect to allow school food authorities to disclose children's free and reduced price meal eligibility information to Medicaid and SCHIP. School food authorities may then elect to do so. Children's program eligibility information may only be disclosed to Medicaid or SCHIP when both the State agency and the school food authority so elect, the parent/guardian does not decline to have their eligibility information disclosed as described in paragraph (f)(5), and the requirements in this paragraph (f) are met.

(2) *What information may we disclose for use by Medicaid and SCHIP?* The State agency or school food authority, as appropriate, may disclose children's names, eligibility status (whether they are eligible for free or reduced price meals or free milk), and any other eligibility information obtained through the free and reduced price meal/milk application or obtained through direct certification to persons directly connected with the administration of Medicaid or SCHIP.

(3) *Who are persons ''directly connected'' with the administration of Medicaid and SCHIP?* State employees and persons authorized under Federal and State Medicaid and SCHIP requirements to carry out initial processing of Medicaid or SCHIP applications or to make eligibility determinations are persons directly connected with the administration of Medicaid and SCHIP for purposes of disclosure of children's free and reduced price meal and free milk eligibility information.

(4) *What are the restrictions on how Medicaid and SCHIP use children's free and reduced price meal and free milk eligibility information?* Medicaid and SCHIP agencies and health insurance program operators receiving children's free and reduced price meal and free milk eligibility information may only use the information to seek to enroll children in Medicaid or SCHIP. The Medicaid and SCHIP enrollment process may include targeting and identifying children from low-income households who are potentially eligible for Medicaid or SCHIP for the purpose of seeking to enroll them in Medicaid or SCHIP.

(5) *Must we notify households of potential disclosure to Medicaid or SCHIP?* The State agency or school food authority, as appropriate, must notify parents/guardians that their children's free or reduced price meal or free milk eligibility information will be disclosed to Medicaid and/or SCHIP unless the parent/guardian elects not to have their information disclosed. Additionally, the State agency or school food authority, as appropriate, must give parents/guardians an opportunity to elect not to have their information disclosed to Medicaid or SCHIP. Only the parent or guardian who is a member of the household or family for purposes of the free and reduced price meal or free milk

application may decline the disclosure of eligibility information. The notification must inform parents/guardians that they are not required to consent to the disclosure, that the information, if disclosed, will be used to identify children eligible for and seek to enroll children in a health insurance program, and that their decision will not affect their children's eligibility for free or reduced price meals or free milk. The notification may be included in the letter/notice to parents/guardians that accompanies the free and reduced price meal or free milk application, on the application itself or in a separate notice provided to parents/guardians. The notice must give parents/guardians adequate time to respond. For children determined eligible through direct certification, the notice of potential disclosure may be included in the document informing parents/guardians of their children's eligibility for free meals or free milk through direct certification.

(6) *May social security numbers be disclosed?* The State agency or school food authority, as appropriate, may disclose social security numbers to any programs or persons authorized to receive all program eligibility information under this paragraph (f), provided parents/guardians have not declined to have their information disclosed. However, State agencies and school food authorities that plan to disclose social security numbers must give notice of the planned use of the social security numbers. This notice must be in accordance with section 7(b) of the Privacy Act of 1974 (5 U.S.C. 552a note). The application must include substantially the following language for disclosures of social security numbers to Medicaid or SCHIP: ''The social security number may also be disclosed to Medicaid and the State Children's Health Insurance Program for the purpose of identifying and seeking to enroll eligible children in one of these health insurance programs.'' This language is in addition to the notice required in paragraph (a)(1) of this section. State agencies and school food authorities are responsible for drafting the appropriate notice for disclosures of social security numbers.

(7) *Are agreements required before disclosing program eligibility information?* The State agency or school food authority, as appropriate, must have a written agreement with the State or local agency or agencies administering Medicaid or SCHIP prior to disclosing children's free and reduced price eligibility information. At a minimum, the agreement must:

(i) Identify the health insurance program or health agency receiving children's eligibility information;

(ii) Describe the information that will be disclosed;

(iii) Require that the Medicaid or SCHIP agency use the information obtained and specify that the information must only be used to seek to enroll children in Medicaid or SCHIP;

(iv) Describe how the information will be protected from unauthorized uses and disclosures;

(v) Describe the penalties for unauthorized disclosure; and

(vi) Be signed by both the Medicaid or SCHIP program or agency and the State agency or school food authority, as appropriate.

(8) *What are the penalties for unauthorized disclosure or misuse of information?* In accordance with section 9(b)(2)(C)(v) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(b)(2)(C)(v)), any individual who publishes, divulges, discloses or makes known in any manner, or to any extent not authorized by statute or this section, any information obtained under this paragraph (f) will be fined not more than $1,000 or imprisoned for up to 1 year, or both.

(9) *What are the State agency's responsibilities regarding disclosures?* State agencies that elect to allow disclosure of children's free and reduced price meal eligibility information to Medicaid or SCHIP, as provided in this paragraph (f), must ensure that any school food authority acting in accordance with that option:

(i) Has a written agreement with the State or local agency or agencies administering health insurance programs for children under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 *et seq.* and 1397aa *et seq.*) that requires the health agencies to use children's free and reduced price meal eligibility information to seek to enroll children in those health insurance programs; and

(ii) Notifies each household of the information that will be disclosed, that the information disclosed will be used only to seek to enroll children in Medicaid or SCHIP and provides each parent/guardian with an opportunity to elect not to have the information disclosed.

Dated: January 5, 2001.

Shirley R. Watkins,

Under Secretary, Food, Nutrition and Consumer Services.

[FR Doc. 01–661 Filed 1–8–01; 10:50 am]

BILLING CODE 3410–30–P

DEPARTMENT OF AGRICULTURE

9 CFR Parts 331 and 381

[Docket No. 00–052F]

Termination of Designation of the State of Missouri With Respect to the Inspection of Meat and Meat Food Products and Poultry and Poultry Food Products

AGENCY: Food Safety and Inspection Service, USDA.

ACTION: Final rule and termination of designation.

SUMMARY: This final rule amends the Federal meat and poultry products inspection regulations by terminating the designation of the State of Missouri under Titles I, II, and IV of the Federal Meat Inspection Act (FMIA) and under sections 1 through 4, 6 through 11, and 12 through 22 of the Poultry Products Inspection Act (PPIA).

DATES: This final rule is effective January 1, 2001.

FOR FURTHER INFORMATION CONTACT: Dr. William F. Leese, Director, Federal-State Relations Staff, Food Safety and Inspection Service; telephone (202) 418–8900 or fax (202) 418–8834.

SUPPLEMENTARY INFORMATION:

Background

Section 301(c) of the FMIA (21 U.S.C. 661(c)) and section 5(c) of the PPIA (21 U.S.C. 454(c)) authorize the Secretary of Agriculture (Secretary) to designate a State as one in which the provisions of Titles I and IV of the FMIA and sections 1–4, 6–11, and 12–22 of the PPIA will apply to operations and transactions wholly within the State after the Secretary has determined that requirements at least ''equal to'' those imposed under the Acts have not been developed and effectively enforced by the State.

On August 18, 1972, the Secretary designated the State of Missouri under section 301(c) of the FMIA and section 5(c) of the PPIA as a State in which the Federal Government is responsible for providing meat and poultry inspection at eligible establishments and for otherwise enforcing the applicable provisions of the FMIA and the PPIA with regard to intrastate activities in the State.

In addition, on January 31, 1975, the Federal Government assumed the responsibility of administering the authorities provided for under sections 202 and 203 of the FMIA (21 U.S.C. 642 and 643) and sections 11(b) and (c) of the PPIA (21 U.S.C. 460(b) and (c)) regarding certain classes of operators of meat and poultry products in Missouri.

These designations were undertaken by the Secretary when he determined that the State of Missouri was not in a position to enforce requirements that are at least ''equal to'' the requirements of FMIA and PPIA enforced by the Federal Government.

The Director of Agriculture of the State of Missouri has advised FSIS that on January 1, 2001, the State of Missouri will be in a position to administer a State meat and poultry products inspection program that includes requirements at least ''equal to'' those imposed under the Federal meat and poultry products inspection program.

Section 301(c) of the FMIA and section 5(c) of the PPIA provide that whenever the Secretary of Agriculture determines that any designated State has developed and will enforce State meat and poultry products inspection requirements at least ''equal to'' those imposed by the Federal Government under the FMIA and the PPIA with regard to intrastate operations and transactions, the Secretary will terminate the designation of such State. The Secretary has determined that the State of Missouri has developed, and will enforce, such a State meat and poultry products inspection program in accordance with the applicable provisions of the FMIA and the PPIA.

Since it does not appear that public participation in this matter would make additional relevant information available to the Secretary under the administrative procedure provisions in 5 U.S.C. 553, it is found upon good cause that such procedure is impracticable and unnecessary.

Executive Order 12866

This final rule is issued in conformance with Executive Order 12886 and has been determined not to be a major rule. It will not result in an annual effect on the economy of $100 million or more and will not adversely affect the economy or any segment of the economy. Because this final rule is not a significant rule under Executive Order 12866, it has not undergone review by the Office of Management and Budget.

Effect on Small Entities

The FSIS Administrator has determined that this action will not have a significant economic impact on a substantial number of small entities, as defined by the Regulatory Flexibility Act (Pub. L. 96–354; 6 U.S.C. 601). As stated above, the State of Missouri is assuming a responsibility, previously limited to the Federal Government, of administering the meat and poultry products inspection program for intrastate operations and transactions.

Additional Public Notification

FSIS has considered the potential civil rights impact of this final rule on minorities, women, and persons with disabilities. Public involvement in all segments of rulemaking and policy development is important. Consequently, in an effort to better ensure that minorities, women, and persons with disabilities are aware of this rulemaking, FSIS will announce it and provide copies of this **Federal Register** publication in the FSIS Constituent Update.

FSIS provides a weekly Constituent Update, which is communicated via fax to more than 300 organizations and individuals. In addition, the update is available on-line through the FSIS web page located at *http://fsis.usda.gov.* The update is used to provide information regarding FSIS policies, procedures, regulations, **Federal Register** notices, FSIS public meetings, recalls, and any other types of information that could affect or be of interest to our constituents and shareholders. The constituent fax list consists of industry, trade, and farm groups, consumer interest groups, allied health professionals, and other persons who have requested to be included. Through these various channels, FSIS is able to provide information to a much broader and diverse audience. For more information and to be added to the constituent fax list, fax your request to (202) 720–5704.

List of Subjects

9 CFR Part 331

Meat inspection.

9 CFR Part 381

Poultry and poultry products.

Accordingly, parts 331 and 381 are amended as follows:

PART 331—[AMENDED]

The authority citation for part 331 continues to read as follows:

Authority: 21 U.S.C. 601–695; 7 CFR 2.17, 2.55.

§ 331.2 [Amended]

1. The table in section 331.2 is amended by removing ''Missouri'' from the ''State'' column and by removing the corresponding date.

§ 331.6 [Amended]

2. The table in section 331.6 is amended by removing ''Missouri'' from the ''State'' column in two places and by removing the corresponding dates.

PART 381—[AMENDED]

3. The authority citation for part 381 continues to read as follows:

Authority: 7 U.S.C. 138F; 7 U.S.C. 450; 21 U.S.C. 451–470; 7 CFR 2.17, 2.55.

§ 381.221 [Amended]

4. The table in section 381.221 is amended by removing ''Missouri'' from the ''States'' column and by removing the corresponding date.

§ 381.224 [Amended]

5. The table in section 381.224 is amended by removing ''Missouri'' from the ''State'' column in two places and by removing the corresponding dates.

Done in Washington, DC, on: January 5, 2001.

Thomas J. Billy,

Administrator.

[FR Doc. 01–743 Filed 1–10–01; 8:45 am]

BILLING CODE 1410–DM–P

DEPARTMENT OF ENERGY

Office of Energy Efficiency and Renewable Energy

10 CFR Part 490

RIN 1904–AB–00

Alternative Fuel Transportation Program; Biodiesel Fuel Use Credit

AGENCY: Office of Energy Efficiency and Renewable Energy, Department of Energy (DOE).

ACTION: Final rule.

SUMMARY: The Department of Energy (DOE) adopts with changes an interim final rule published on May 19, 1999, to implement the Energy Conservation Reauthorization Act of 1998 (ECRA). This Act amended title III of the Energy Policy Act of 1992 (EPACT). ECRA allows fleets that are required to purchase alternative fueled vehicles under titles III and V of EPACT to meet these requirements, in part, through the use of biodiesel fuel use credits. The rule establishes procedures for fleets and covered persons to request credits for specified biodiesel fuel use and implements ECRA's credit eligibility and allocation provisions. The biodiesel fuel use credit gives fleets and covered persons, who are otherwise required under EPACT to purchase an alternative fueled vehicle, the option of purchasing and using 450 gallons of biodiesel in vehicles in excess of 8,500 pounds gross vehicle weight instead of acquiring an alternative fueled vehicle.

DATES: This final rule is effective February 12, 2001.

FOR FURTHER INFORMATION CONTACT: David Rodgers, Office of Energy Efficiency and Renewable Energy, EE–34, U.S. Department of Energy, 1000 Independence Avenue, SW., Washington, DC 20585, (202) 586–9118.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background
II. Section-by-Section Discussion of Public Comments and Rule Provisions
A. Section 490.703—Biodiesel Fuel Use Credit Allocation
B. Section 490.704—Procedures and Documentation
C. Section 490.705—Use of Credits
D. Section 490.707—Increasing the Qualifying Volume of the Biodiesel Component
III. Regulatory and Procedural Requirements
A. Review Under Executive Order 12866
B. Review Under Executive Order 12612
C. Review Under the Regulatory Flexibility Act
D. Review Under the National Environmental Policy Act
E. Review Under the Paperwork Reduction Act
F. Review Under Executive Order 12988
G. Review Under the Unfunded Mandates Reform Act of 1995
H. Congressional Notification

I. Introduction and Background

This notice of final rulemaking concludes a regulatory action that is mandated under section 7 of the Energy Conservation Reauthorization Act of 1998 (ECRA), Pub. L. No. 105–388. ECRA adds section 312 to title III of the Energy Policy Act of 1992 (EPACT), 42 U.S.C. 13211–13219. Section 312 allows titles III and V fleets and covered persons, that are required to acquire certain annual percentages of alternative fueled vehicles, to use biodiesel fuel use credits to meet, in part, these acquisition requirements. (Although title IV is included as one of the titles covered in ECRA, this inclusion appears to be a drafting error since title IV has no mandated acquisition requirements for fleets and covered persons.) DOE is required to allocate one credit to fleets and covered persons for using, in certain vehicles, 450 gallons (or ''qualifying volume'') of the biodiesel component of a motor fuel containing at least 20 percent biodiesel by volume.

Additionally, the vehicles in which the fuel is used must weigh more than 8,500 pounds gross vehicle weight rating. Fleets and covered persons must own or operate these vehicles and the biodiesel fuel must be used in these vehicles if the fleets and covered persons are to receive credits. Credits will be allocated only for the biodiesel fuel purchased after the enactment of ECRA, *i.e.,* November 13, 1998. The legislation prohibits the allocation of biodiesel fuel use credits for the purchase of biodiesel when the biodiesel is used in alternative fueled vehicles that are utilized to satisfy the EPACT alternative fueled vehicle purchase requirements, or when biodiesel fuel use is required by Federal or State law. With the exception of biodiesel fuel providers, allocated credits can be used to satisfy up to 50 percent of a fleet's or covered person's alternative fueled vehicles requirements. For biodiesel fuel providers, biodiesel credits can satisfy up to 100 percent of the requirements.

On May 19, 1999, DOE issued an interim final rule (64 FR 27169) that added a new subpart H to DOE's Alternative Fuel Transportation Program rules at 10 CFR part 490. The interim final rule became effective on June 18, 1999. The interim final rule established procedures for fleets that are required to purchase alternative fueled vehicles under titles III and V of EPACT to meet these requirements, in part, through the use of biodiesel fuel use credits. With changes, this final rule adopts the interim final rule.

II. Section-by-Section Discussion of Public Comment and Rule Provisions

DOE received from 10 interested organizations comments on the interim final rule. Most commenters addressed essentially the same issues.

A. Section 490.703—Biodiesel Fuel Use Credit Allocation

Five commenters all argued that there is no evidence that Congress intended to compel the use of biodiesel within the model year in which the biodiesel is purchased. It appears that the commenters wish to carry forward unused biodiesel to another model year or that they wish to sell excess purchases of biodiesel to other fleets. DOE believes that ECRA bases the allocation of biodiesel fuel use credits on biodiesel purchases. However, DOE points out that ECRA requires that the fuel must be purchased for use in the covered entities' vehicles to earn credits. Credits are earned when the fuel is purchased for use in the covered entities' vehicles, even though the fuel may be used at a later date. On this issue, DOE explained in the Preamble that ''[t]he use of biodiesel fuel credit to serve as the acquisition of one alternative fueled vehicle is restricted to the model year, or the fiscal year in the case of Federal fleets, in which the biodiesel is purchased and cannot be carried forward like alternative fueled vehicle acquisition credits generated under Subpart F.'' DOE reinforced this statement by citing language from the House of Representatives Commerce Committee Report 105–727. That report provided that credits ''may only be used by the fleet or covered person that earned the credits and only in the year that the credit is issued, so they cannot be traded or banked.'' H.R. Rep. No. 727, 105th Cong., 2d Sess., at 20 (1998). (See also the discussion under section 490.705.)

Three commenters submitted similar comments on language contained in section 490.703 (b). That paragraph prohibits the allocation of biodiesel fuel use credits if: (1) the biodiesel is used in an alternative fueled vehicle; or (2) if the biodiesel fuel use is required by Federal or State law. They argue that there are certain circumstances where a covered fleet may want to acquire an alternative fueled vehicle (AFV) as a result of a local, State or Federal incentive program or policy, unrelated to EPACT AFV purchase requirements. Allowing fleets to count biodiesel fuel used in AFVs, provided those AFVs are not used to meet EPACT AFV requirements, according to one commenter, would increase the flexibility of covered fleets to integrate biodiesel fuel into their fuel mix. This commenter recommends that DOE amend the language in section 490.703(b) in two ways. First, that DOE clarify that the prohibition against allocating a credit for biodiesel fuel use in AFVs be restricted to only AFVs used to meet EPACT AFV purchase requirements. DOE agrees with this comment and has integrated it into the final regulatory language.

Second, this commenter suggests that DOE delete the prohibition against allocating a credit where biodiesel fuel use is also used to meet other Federal or State requirements. DOE does not agree with this comment. The statutory language in ECRA states quite clearly that no credit can be allocated if the fuel is required by Federal or State law. This prohibition appears to be intended to prevent fleets from meeting both EPACT and other Federal and State requirements through the same biodiesel fuel use.

B. Section 490.704—Procedures and Documentation

Eight commenters argued that the procedures and documentation requirements of section 490.704 should include only that information that is necessary to support the verification of the biodiesel fuel purchase. They claim that asking for information on vehicle make and model, vehicle model year and vehicle identification number does not relate to fuel purchases of biodiesel and could make reporting more onerous. Providing such information would

impose an unnecessary burden on the reporting entities. DOE agrees that requesting specific vehicle data may be burdensome, and believes that asking for such data may reduce the attractiveness of the biodiesel fuel use credit option. DOE has, therefore, revised the Annual Alternative Fuel Vehicle Acquisition Report For State Government and Alternative Fuel Provider Fleets (DOE/OTT/101 form). The revised form only requests that fleets claiming the biodiesel fuel use credit submit model year specific biodiesel purchases and that such fleets maintain records of those purchases for three years. The updated form is posted on the DOE's Office of Transportation Technologies website at *http://www.ott.doe.gov/credits.* It can also be obtained by calling the National Alternative Fuels Hotline at 1–800–423–1DOE.

C. Section 490.705—Use of Credits

Most commenters argued that the language in Sections 705(a) and (b) is too narrow in limiting the biodiesel fuel use credit to fleets covered by section 490.201, section 490.302, section 490.307 and title III of EPACT. A consequence of narrowing the language, according to these commenters, is that the biodiesel fuel use credit regulation may not apply to certain private and municipal fleets if DOE adds these fleets to the Alternative Fuel Transportation Program. These commenters recommend expanding the regulatory language so that it applies to fleets or covered persons identified in EPACT titles III and V, rather than the specific sections in the regulation. DOE believes that the current regulatory language is appropriate. Specifically, DOE noted in the Preamble that these fleets would be covered if DOE decides to include them under this subpart in the Alternative Fuel Transportation Program. Section 490.701 also acknowledges that Title V fleets are covered under this subpart. However, DOE recognizes that the rule language could have been clearer. Therefore the language in sections 705(a) and 705(b) has been amended to include references only to EPACT titles III and V.

Seven commenters argued that section 490.705(a) should not restrict the allocation of a biodiesel fuel use credit to the model year in which it is generated. They also contended that fleets should be able to trade excess credits to other covered fleets or bank excess credits for future model years. One commenter asserts that this limitation will prevent over compliance and reduce the likelihood of achieving higher volumes and economies of scale in biodiesel production. Six commenters meanwhile, claim that DOE's reliance on the House of Representatives Commerce Committee Report 105–727 for this restriction is misplaced. They contend that this is not the intent of Congress, and that the restriction would have an adverse impact on the production, sale and use of biodiesel.

Although DOE respects the commenters' views, DOE has not revised section 490.705. We believe that both the statutory language and the House of Representatives Commerce Committee Report support the restriction. Section 312(b)(1) of EPACT, as amended by ECRA, declares that a credit is to be allocated in the year in which the purchase of a qualifying volume of biodiesel is made. Furthermore, section 312(c) states that a credit under this section shall not be considered a credit as defined by section 508 of EPACT. DOE believes that this statutory view is supported by the House of Representatives Commerce Committee Report 105–727. It stated that biodiesel fuel use credits ''may only be used by the fleet or covered person that earned the credits and only in the year the credit is issued, so they cannot be traded or banked.'' [1] For these reasons, the rule cannot allow trading or banking of biodiesel fuel use credits. To avoid future questions on this issue, DOE has added to this section a new paragraph (d). Paragraph (d) specifically speaks to this prohibition.

D. Section 490.707—Increasing the Qualifying Volume of the Biodiesel Component

One commenter suggested that DOE annually publish in the **Federal Register** the ''qualifying volume,'' which is the amount of biodiesel purchases required to be allocated one biodiesel fuel use credit. As reflected in section 490.707, section 312(d) gives DOE authority, via rulemaking, to increase the qualifying volume. Since the qualifying volume is set at 450 gallons and cannot be changed except via a rulemaking process, DOE sees no reason to annually publish the qualifying volume in the **Federal Register**. Thus, DOE has not revised this section. Interested parties can be assured that the qualifying volume will stay at 450 gallons, unless DOE commences a rulemaking to increase it. If this happens, DOE will notify the public via a **Federal Register** notice. DOE will provide ample time and opportunity for the public to submit comments.

[1] H.R. Rep. No. 727, 105th Cong., 2d Sess. at 20 (1998).

III. Regulatory and Procedural Requirements

A. Review Under Executive Order 12866

Today's regulatory action has been determined not to be a ''significant regulatory action'' under Executive Order 12866, ''Regulatory Planning and Review,'' 58 FR 51735 (October 4, 1993). Accordingly, this rulemaking has not been reviewed by the Office of Information and Regulatory Affairs of the Office of Management and Budget.

B. Review Under Executive Order 13132

Executive Order 13132 (64 FR 43255, August 10, 1999) requires agencies 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 are 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.'' On March 14, 2000, DOE published a statement of policy describing the intergovernmental consultation process it will follow in the development of such regulations (65 FR 13735). DOE has examined today's rule and determined that it does 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. No further action is required by the Executive Order.

C. Review Under the Regulatory Flexibility Act

The Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, requires preparation of an initial regulatory flexibility analysis for every rule for which the law requires publication of a general notice of proposed rulemaking unless the agency certifies that the rule, if promulgated, will not have a significant economic impact on a substantial number of small entities. The Regulatory Flexibility Act's requirements do not apply to this final rule because a general notice of proposed rulemaking was not required by law. Accordingly, DOE did not prepare a regulatory flexibility analysis for this rule.

D. Review Under the National Environmental Policy Act

The Department has determined that this rule is covered by categorical

exclusion in paragraph A5 to subpart D, 10 CFR part 1021. Accordingly, neither an environmental assessment nor an environmental impact statement is required.

E. Review Under the Paperwork Reduction Act

This final rule contains a collection of information that the Office of Management and Budget (OMB) reviews under the Paperwork Reduction Act of 1995. The Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35) requires agencies to submit information collection requests for OMB review and approval. Accordingly, DOE submitted to OMB the interim final rule. DOE sought public comments on: (1) Whether the proposed collection of information is necessary, (2) the accuracy of DOE's estimate of the burden of the proposed information collection, (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) ways to minimize the burden of the collection of information on those who choose to respond.

As mentioned in this rule's Preamble, several entities submitted comments recommending that DOE only require information that is necessary to verify the biodiesel fuel purchase. In particular, they contended that DOE should not require information on vehicle make and model, vehicle model year and vehicle identification number. They opined that this information does not relate to fuel purchases of biodiesel and would impose an unnecessary burden on the reporting entities. DOE incorporated these recommendations into its information collection request to OMB.

On October 25, 1999, DOE issued a **Federal Register** notice (64 FR 57445) that announced that DOE had submitted to OMB a proposed information collection request for the collection of biodiesel purchase data from fleets participating in DOE's Alternative Fuel Transportation Program. No additional comments were received in response to the October 25, 1999, **Federal Register** notice. During the OMB review period, DOE issued interim reporting guidance and placed that guidance on DOE's Office of Transportation Technologies website at *http://www.ott.doe.gov/credits.*

On February 2, 2000, OMB approved the biodiesel data collection and revised the Annual Alternative Fuel Vehicle Acquisition Report For State Government and Alternative Fuel Provider Fleets (DOE/OTT/101 form, approved under OMB Control No. 1910–5101). Fleets claiming the biodiesel fuel use credit must submit to DOE model year specific biodiesel purchases and maintain records of those purchases for three years. The updated form is posted on the DOE's Office of Transportation Technologies website at *http://www.ott.doe.gov/credits* or can be obtained by calling the National Alternative Fuels Hotline at 1–800–423–1DOE.

F. Review Under Executive Order 12988

With respect to the review of existing regulations and the promulgation of new regulations, section 3(a) of Executive Order 12988, ''Civil Justice Reform,'' 61 FR 4729 (February 7, 1996) imposes on executive agencies the general duty to adhere to the following requirements: (1) Eliminate drafting errors and ambiguity; (2) write regulations to minimize litigation; and (3) provide a clear legal standard for affected conduct rather than a general standard and promote simplification and burden reduction. Section 3(b) of Executive Order 12988 specifically requires that executive agencies make every reasonable effort to ensure that the regulation: (1) Clearly specifies the preemptive effect, if any; (2) clearly specifies any effect on existing Federal law or regulation; (3) provides a clear legal standard for affected conduct, while promoting simplification and burden reduction; (4) specifies the retroactive effect, if any; (5) adequately defines key terms; and (6) addresses other important issues affecting clarity and general draftsmanship under any guidelines issued by the Attorney General. Section 3(c) of Executive Order 12988 requires executive agencies to review regulations in light of applicable standards in section 3(a) and section 3(b) to determine whether they are met or it is unreasonable to meet one or more of them. DOE has completed the required review and determined that, to the extent permitted by law, this final rule meets the relevant standards of Executive Order 12988.

G. Review Under the Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires each Federal agency to prepare a written assessment of the effects of any Federal mandate in a proposed or final agency rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million in any one year. The Act also requires a Federal agency to develop an effective process to permit timely input by elected officers of State, local, and tribal governments on a proposed ''significant intergovernmental mandate.'' Additionally, it requires an agency plan for giving notice and opportunity for timely input to potentially affected small governments before establishing any requirements that might significantly or uniquely affect small governments. The final rule published today does not contain any Federal mandate, so these requirements do not apply.

H. Congressional Notification

As required by 5 U.S.C. 801, DOE will report to Congress the promulgation of this rule prior to its effective date. The report will state that it has been determined that the rule is not a ''major rule'' as defined by 5 U.S.C. 801(2).

List of Subjects in 10 CFR Part 490

Administrative practice and procedure, Energy conservation, Fuel, Motor vehicles.

Issued in Washington, DC, on January 4, 2001.

Dan W. Reicher,

Assistant Secretary, Energy Efficiency and Renewable Energy.

Accordingly, the interim final rule amending part 490 of title 10, chapter II, subchapter D of the Code of Federal Regulations, which was published at 64 FR 27169 on May 19, 1999, is adopted as a final rule with the following changes:

PART 490—ALTERNATIVE FUEL TRANSPORTATION PROGRAM

1. The authority citation for part 490 is revised to read as follows:

Authority: 42 USC. 7191, 13211–13212, 13220, 13235, 13251, 13257, 13260–13263.

2. Amend § 490.703 by revising paragraph (b) to read as follows:

§ 490.703 Biodiesel fuel use credit allocation.

* * * * *

(b) No credit shall be allocated under this subpart for a purchase of the biodiesel component of a fuel if the fuel is:

(1) For use in alternative fueled vehicles which have been used to satisfy the alternative fueled vehicle acquisition requirements under Titles III and V of the Energy Policy Act of 1992; or

(2) Required by Federal or State law.

3. Amend § 490.705 by revising paragraphs (a) and (b) and adding paragraph (d) to read as follows:

§ 490.705 Use of Credits.

(a) At the request of a fleet or covered person allocated a credit under this subpart, DOE shall, for the model year

in which the purchase of a qualifying volume is made, treat that purchase as the acquisition of one alternative fueled vehicle the fleet or covered person is required to acquire under titles III and V of the Energy Policy Act of 1992.

(b) Except as provided in paragraph (c) of this section, credits allocated under this subpart may not be used to satisfy more than 50 percent of the alternative fueled vehicle requirements of a fleet or covered person under titles III and V of the Energy Policy Act of 1992.

* * * * *

(d) A fleet or covered person may not trade or bank biodiesel fuel credits.

[FR Doc. 01–744 Filed 1–10–01; 8:45 am]

BILLING CODE 6450–01–P

FEDERAL RESERVE SYSTEM

12 CFR Part 201

[Regulation A]

Extensions of Credit by Federal Reserve Banks; Change in Discount Rate

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Final rule.

SUMMARY: The Board of Governors has amended its Regulation A on Extensions of Credit by Federal Reserve Banks to reflect its approval of a decrease in the basic discount rate at each Federal Reserve Bank. The Board acted on requests submitted by the Boards of Directors of the twelve Federal Reserve Banks.

DATES: The amendments to part 201 (Regulation A) were effective January 4, 2001. The rate changes for adjustment credit were effective on the dates specified in 12 CFR 201.51.

FOR FURTHER INFORMATION CONTACT: Jennifer J. Johnson, Secretary of the Board, at (202) 452–3259; for users of Telecommunications Device for the Deaf (TDD), contact Janice Simms, at (202) 872–4984, Board of Governors of the Federal Reserve System, 20th and C Streets NW., Washington, DC 20551.

SUPPLEMENTARY INFORMATION: Pursuant to the authority of sections 10(b), 13, 14, 19, *et al.,* of the Federal Reserve Act, the Board has amended its Regulation A (12 CFR part 201) to incorporate changes in discount rates on Federal Reserve Bank extensions of credit. The discount rates are the interest rates charged to depository institutions when they borrow from their district Reserve Banks.

The ''basic discount rate'' is a fixed rate charged by Reserve Banks for adjustment credit and, at the Reserve Banks' discretion, for extended credit for up to 30 days. In decreasing the basic discount rate from 6.0 percent to 5.5 percent, the Board acted on requests submitted by the Boards of Directors of the twelve Federal Reserve Banks. The new rate of 5.5 percent was effective for all twelve Reserve Banks on the dates specified below. (Seven of the twelve Reserve Banks reduced the basic discount rate in two steps, from 6.0 percent to 5.75 percent, then from 5.75 percent to 5.5 percent, as specified in the footnote to § 201.51 of revised Regulation A.) The 50-basis-point decrease in the discount rate was associated with a 50-basis-point decrease in the federal funds rate approved by the Federal Open Market Committee.

These actions were taken in light of further weakening of sales and production, and in the context of lower consumer confidence, tight conditions in some segments of financial markets, and high energy prices sapping household and business purchasing power. Moreover, inflation pressures remain contained. Nonetheless, to date there is little evidence to suggest that longer-term advances in technology and associated gains in productivity are abating.

Regulatory Flexibility Act Certification

Pursuant to section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 605(b)), the Board certifies that the change in the basic discount rate will not have a significant adverse economic impact on a substantial number of small entities. The rule does not impose any additional requirements on entities affected by the regulation.

Administrative Procedure Act

The provisions of 5 U.S.C. 553(b) relating to notice and public participation were not followed in connection with the adoption of the amendment because the Board for good cause finds that delaying the change in the basic discount rate in order to allow notice and public comment on the change is impracticable, unnecessary, and contrary to the public interest in fostering price stability and sustainable economic growth.

The provisions of 5 U.S.C. 553(d) that prescribe 30 days prior notice of the effective date of a rule have not been followed because section 553(d) provides that such prior notice is not necessary whenever there is good cause for finding that such notice is contrary to the public interest. As previously stated, the Board determined that delaying the changes in the basic discount rate is contrary to the public interest.

List of Subjects in 12 CFR Part 201

Banks, banking, Credit, Federal Reserve System.

For the reasons set out in the preamble, 12 CFR part 201 is amended as set forth below:

PART 201—EXTENSIONS OF CREDIT BY FEDERAL RESERVE BANKS (REGULATION A)

1. The authority citation for 12 CFR part 201 continues to read as follows:

Authority: 12 U.S.C. 343 *et seq.*, 347a, 347b, 347c, 347d, 348 *et seq.*, 357, 374, 374a and 461.

2. Section 201.51 is revised to read as follows:

§ 201.51 Adjustment credit for depository institutions.

The rates for adjustment credit provided to depository institutions under § 201.3(a) are:

Federal Reserve Bank	Rate	Effective [1]
Boston	5.5	January 4, 2001
New York	5.5	January 4, 2001
Philadelphia	5.5	January 4, 2001
Cleveland	5.5	January 4, 2001
Richmond	5.5	January 4, 2001
Atlanta	5.5	January 4, 2001
Chicago	5.5	January 4, 2001
St. Louis	5.5	January 5, 2001
Minneapolis	5.5	January 4, 2001
Kansas City	5.5	January 4, 2001
Dallas	5.5	January 4, 2001
San Francisco	5.5	January 4, 2001

[1] On January 3, 2001, the rate for adjustment credit was 5.75 percent for the following Federal Reserve Banks: New York, Cleveland, Atlanta, Kansas City, Dallas, and San Francisco. On January 4, the rate for adjustment credit was 5.75 percent for the Federal Reserve Bank of St. Louis.

By order of the Board of Governors of the Federal Reserve System, January 5, 2001.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 01–784 Filed 1–10–01; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–CE–82–AD; Amendment 39–12069; AD 2000–26–19]

RIN 2120–AA64

Airworthiness Directives; SOCATA—Groupe AEROSPATIALE Model TBM 700 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to certain SOCATA—Groupe AEROSPATIALE (Socata) Model TBM 700 airplanes. This AD requires you to inspect for a low point in the fuel tank air vent valve hose; and reroute the hose as necessary. This AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for France. The actions specified by this AD are intended to prevent in-flight damage to the wing skins caused by abnormal venting conditions of the wing fuel tank, which could result in severe handling problems or reduced structural capability. Continued operation with such structural deformation or handling problems could result in loss of control of the airplane.

DATES: This AD becomes effective on February 2, 2001.

The Director of the Federal Register approved the incorporation by reference of certain publications listed in the regulation as of February 2, 2001.

The Federal Aviation Administration (FAA) must receive any comments on this rule by February 15, 2001.

ADDRESSES: Send three copies of comments to FAA, Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 2000–CE–82–AD, 901 Locust, Room 506, Kansas City, Missouri 64106.

You may get service information referenced in this AD from SOCATA Groupe AEROSPATIALE, Customer Support, Aerodrome Tarbes-Ossun-Lourdes, BP 930—F65009 Tarbes Cedex, France; telephone: (33) (0)5.62.41.73.00; facsimile: (33) (0)5.62.41.76.54; or the Product Support Manager, SOCATA—Groupe AEROSPATIALE, North Perry Airport, 7501 Pembroke Road, Pembroke Pines, Florida 33023; telephone: (954) 894–1160; facsimile: (954) 964–4191. You may read this information at FAA, Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 2000–CE–821–AD, 901 Locust, Room 506, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW, suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4146; facsimile: (816) 329–4090.

SUPPLEMENTARY INFORMATION:

Discussion

What events have caused this AD? The Direction Geenerale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, recently notified FAA that an unsafe condition may exist on certain Socata Model TBM 700 airplanes. The DGAC reports two occurrences on Socata Model TBM 700 airplanes of abnormal venting conditions of the wing fuel tank.

One occurrence was where an airplane experienced leaking during refueling. Inspection revealed the wing skin had come apart from the rib breaking the sealer, allowing the fuel to leak.

Another reported occurrence was in-flight where the pilot saw a wing skin deformation. These occurrences are caused by low pressure resulting from a misrouted fuel tank air vent valve hose and the fuel tank vent not operating.

What are the consequences if the condition is not corrected? This condition, if not corrected, could result in severe handling problems or reduced structural capability. Continued operation with such structural deformation or handling problems could result in loss of control of the airplane.

Is there service information that applies to this subject? Socata has issued Service Bulletin SB 70–088, dated November 2000. This service bulletin includes procedures for:

—Inspecting for a low point in the fuel tank air vent valve hose; and
—Rerouting the hose as necessary.

What action did DGAC take? The DGAC classified this service bulletin as mandatory and issued French AD T2000–545(A), dated December 20, 2000, to ensure the continued airworthiness of these airplanes in France.

Was this in accordance with the bilateral airworthiness agreement? 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.

In carrying out this bilateral airworthiness agreement, the DGAC has kept FAA informed of the situation described above.

The FAA's Determination and an Explanation of the Provisions of the AD

What has FAA decided? The FAA has examined the findings of the DGAC; reviewed all available information, including the service information referenced above; and determined that:

—The unsafe condition referenced in this document exists or could develop on other Socata Model TBM 700 airplanes of the same type design;
—The actions specified in the previously-referenced service information (as specified in this AD) should be accomplished on the affected airplanes; and
—AD action should be taken in order to correct this unsafe condition.

What does this AD require? This AD requires you to do the actions previously specified in accordance with Socata Service Bulletin SB 70–088, dated November 2000.

Will I have the opportunity to comment prior to the issuance of the rule? Because the unsafe condition described in this document could result in structural failure with possible loss of control of the airplane, FAA finds that notice and opportunity for public prior comment are impracticable. Therefore, good cause exists for making this amendment effective in less than 30 days.

Comments Invited

How do I comment on this AD? Although this action is in the form of a final rule and was not preceded by notice and opportunity for public comment, we invite your comments on the rule. You may send whatever written data, views, or arguments you choose. You need to include the rule's docket number and send three copies of your comments to the address specified under the caption **ADDRESSES**. We will consider all comments received by the closing date specified above. We may change this rule in light of comments received. Factual information that supports your ideas and suggestions is extremely helpful in evaluating the effectiveness of the AD action and determining whether we need to take additional rulemaking action.

Are there any specific portions of the AD I should pay attention to? The FAA specifically invites comments on the overall regulatory, economic, environmental, and energy aspects of

the rule that might require a change to the rule. You may look at all comments we receive. We will file a report in the Rules Docket that summarizes each FAA contact with the public that concerns the substantive parts of this proposal.

We are reviewing the writing style we currently use in regulatory documents, in response to the Presidential memorandum of June 1, 1998. That memorandum requires federal agencies to communicate more clearly with the public. We are interested in your comments on whether the style of this document is clear, and any other suggestions you might have to improve the clarity of FAA communications that affect you. You can get more information about the Presidential memorandum and the plain language initiative at *http://www.plainlanguage.gov.*

How can I be sure FAA receives my comment? If you want us to acknowledge the receipt of your comments, you must include a self-addressed, stamped postcard. On the postcard, write ''Comments to Docket No. 2000–CE–82–AD.'' We will date stamp and mail the postcard back to you.

Regulatory Impact

Does this AD impact various entities? These regulations will not have a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, FAA has determined that this final rule does not have federalism implications under Executive Order 13132.

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

List of Subjects in 14 CFR Part 39

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

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. FAA amends § 39.13 by adding a new airworthiness directive (AD) to read as follows:

2000–26–19 SOCATA—Groupe Aerospatiale: Amendment 39–12069; Docket No. 2000–CE–82–AD.

(a) *What airplanes are affected by this AD?* This AD affects Model TBM 700 airplanes, serial numbers 1 through 182, that are certificated in any category.

(b) *Who must comply with this AD?* Anyone who wishes to operate any of the above airplanes must comply with this AD.

(c) *What problem does this AD address?* The actions specified by this AD are intended to prevent in-flight damage to the wing skins caused by abnormal venting conditions of the wing fuel tank, which could result in severe handling problems or reduced structural capability. Continued operation with such structural deformation could result in loss of control of the airplane.

(d) *What must I do to address this problem?* To address this problem, unless already done, you must do the following actions:

Action	Compliance time	Procedures
(1) Inspect for a low point in the fuel tank air vent valve hose.	Within the next 5 hours time-in-service (TIS) after February 2, 2001 (the effective date of this AD).	Do this action following the ACCOMPLISHMENT INSTRUCTIONS paragraph in Socata Service Bulletin SB 70–088, dated November 2000, and the applicable maintenance manual.
(2) If there is a low point in the fuel tank air vent valve hose, reroute the hose.	Before further flight after the inspection	Do this action following the ACCOMPLISHMENT INSTRUCTIONS paragraph in Socata Service Bulletin SB 70–088, dated November 2000, and the applicable maintenance manual.

(e) *Can I comply with this AD in any other way?* You may use an alternative method of compliance or adjust the compliance time if:

(1) Your alternative method of compliance provides an equivalent level of safety; and

(2) The Manager, Small Airplane Directorate, approves your alternative. Send your request through an FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Small Airplane Directorate.

Note 1: This AD applies to each airplane identified in paragraph (a) of this AD, 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 (e) 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 you have not eliminated the unsafe condition, specific actions you propose to address it.

(f) *Where can I get information about any already-approved alternative methods of compliance?* Contact Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 901 Locust, Room 301, Kansas City, Missouri 64106; telephone: (816) 329–4146; facsimile: (816) 329–4090.

(g) *What if I need to fly the airplane to another location to comply with this AD?* The FAA can issue a special flight permit under sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate your airplane to a location where you can accomplish the requirements of this AD.

(h) *Are any service bulletins incorporated into this AD by reference?* Actions required by this AD must be done following Socata Service Bulletin 70–088, dated November 2000. The Director of the Federal Register approved this incorporation by reference under 5 U.S.C. 552(a) and 1 CFR part 51. You can get copies from SOCATA Groupe AEROSPATIALE, Customer Support, Aerodrome Tarbes-Ossun-Lourdes, BP 930–F65009 Tarbes Cedex, France; or the Product Support Manager, SOCATA—Groupe AEROSPATIALE, North Perry Airport, 7501 Pembroke Road, Pembroke Pines, Florida 33023. You can look at copies at FAA, Central Region, Office of the Regional

Counsel, 901 Locust, Room 506, Kansas City, Missouri, or at the Office of the Federal Register, 800 North Capitol Street, NW, suite 700, Washington, DC .

(i) *When does this amendment become effective?* This amendment becomes effective on February 2, 2001.

Note 2: The subject of this AD is addressed in French AD T2000–545(A), dated December 20, 2000.

Issued in Kansas City, Missouri, on December 29, 2000.

David R. Showers,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 01–307 Filed 1–10–01; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 00–ACE–28]

Amendment to Class E Airspace; Pittsburg, KS

AGENCY: Federal Aviation Administration, DOT.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: This document confirms the effective date of a direct final rule which revises Class E airspace at Pittsburg, KS.

EFFECTIVE DATE: 0901 UTC, March 22, 2001.

FOR FURTHER INFORMATION CONTACT: Kathy Randolph, Air Traffic Division, Airspace Branch, ACE–520C, DOT Regional Headquarters Building, Federal Aviation Administration, 901 Locust, Kansas City, MO 64106; telephone: (816) 329–2525.

SUPPLEMENTARY INFORMATION: The FAA published this direct final rule with a request for comments in the **Federal Register** on October 24, 2000 (65 FR 63544). The FAA uses the direct final rulemaking procedure for a non-controversial 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 march 22, 2001. No adverse comments were received, and thus this notice confirms that this direct final rule will become effective on that date.

Issued in Kansas City, MO on December 15, 2000.

Herman J. Lyons, Jr.,

Manager, Air Traffic Division, Central Region.

[FR Doc. 01–705 Filed 1–10–01; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF JUSTICE

Drug Enforcement Administration

21 CFR PART 1306

[DEA–190F]

RIN 1117–AA54

Facsimile Transmission of Prescriptions for Patients Enrolled in Hospice Programs

AGENCY: Drug Enforcement Administration (DEA), Justice.

ACTION: Final rule.

SUMMARY: DEA is finalizing, without change, the interim rule with request for comment published in the **Federal Register** on July 25, 2000 (65 FR 45712). The interim rule amended Title 21, Code of Federal Regulations (CFR) 1306.11(g) to clearly articulate that prescriptions for Schedule II narcotic substances for patients enrolled in hospice care certified by Medicare under Title XVIII or licensed by the state may be transmitted by facsimile. No comments to the interim rule were received. This final rule makes the clarification permanent.

EFFECTIVE DATE: February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, telephone (202) 307–7297.

SUPPLEMENTARY INFORMATION:

What Does This Final Rule Accomplish?

On July 25, 2000 DEA published an interim rule with request for comment (65 FR 45712) amending 21 CFR 1306.11(g) to clearly articulate that prescriptions for Schedule II narcotic substances for patients enrolled in hospice care certified by Medicare under Title XVIII or licensed by the state, regardless of whether the patient resides in a hospice facility or other care setting, may be transmitted by facsimile. This final rule makes the clarification permanent.

Why Was Clarification of the Regulation Necessary?

Section 1306.11(g) of the regulations originally provided that a pharmacy could dispense a Schedule II narcotic substance pursuant to a prescription transmitted to the pharmacy via facsimile for a patient residing in a hospice certified by Medicare under Title XVIII or licensed by the state. The use of the language ''residing in a hospice certified by Medicare under Title XVIII or licensed by the state'' was perceived by the regulated industry as requiring that the patient reside in a hospice facility to the exclusion of other care settings, such as home hospice care. DEA regulations were meant to cover all patients enrolled in hospice programs certified by Medicare under Title XVIII or licensed by the state, regardless of where the patient resides.

The interim rule amended Section 1306.11(g) to refer to ''* * * a patient enrolled in a hospice care program certified and/or paid for by Medicare under Title XVIII or a hospice program which is licensed by the state'' to clarify that prescriptions for Schedule II narcotic substances for patients enrolled in recognized hospice programs, regardless of where the patients reside, may be transmitted via facsimile.

What Comments Were Received Regarding the Interim Rule?

No comments were submitted regarding this interim rulemaking. Accordingly, the interim rule amending 21 CFR part 1306, which was published in the **Federal Register** on July 25, 2000, at 65 FR 45712 is adopted as a final rule.

Regulatory Certifications

Regulatory Flexibility Act

The Deputy Assistant Administrator hereby certifies that this rulemaking has been drafted in a manner consistent with the principles of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). It will not have a significant economic impact on a substantial number of small business entities. This rulemaking clarifies the regulations regarding the facsimile transmission of prescriptions for Schedule II narcotic substances for patients enrolled in hospice programs.

Executive Order 12866

The Deputy Assistant Administrator further certifies that this rulemaking has been drafted in accordance with the principles in Executive Order 12866, Section 1(b). DEA has determined that this is not a significant rulemaking action. This rulemaking clarifies the regulations regarding the facsimile transmission of prescriptions for Schedule II narcotic substances for patients enrolled in hospice programs. Therefore, this action has not been

reviewed by the Office of Management and Budget.

Executive Order 12988

This regulation meets the applicable standards set forth in Sections 3(a) and 3(b)(2) of Executive Order 12988 Civil Justice Reform.

Executive Order 13132

This rulemaking does not preempt or modify any provision of state law; nor does it impose enforcement responsibilities on any state; nor does it diminish the power of any state to enforce its own laws. Accordingly, this rulemaking does not have federalism implications warranting the application of Executive Order 13132.

Unfunded Mandates Reform Act of 1995

This rule will not result in the expenditure by state, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more in any one year, and will not significantly or uniquely affect small governments. Therefore, no actions were deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by section 804 of the Small Business Regulatory Enforcement Fairness Act of 1996. This rule will not result in an annual effect on the economy of $100,000,000 or more; a major increase in costs or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete with foreign-based companies in domestic and export markets.

Plain Language Instructions

The Drug Enforcement Administration makes every effort to write clearly. If you have suggestions as to how to improve the clarity of this regulation, call or write Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, Washington, DC 20537, telephone (202) 307–7297.

The interim rule amending 21 CFR part 1306, which was published in the **Federal Register** on July 25, 2000, at 65 FR 45712, is adopted as a final rule without change.

Dated: December 28, 2000.

John H. King,

Deputy Assistant Administrator, Office of Diversion Control.

[FR Doc. 01–545 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–09–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[TD 8927]

RIN 1545–AW34

Conversion to the Euro

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document contains final Income Tax Regulations relating to U.S. taxpayers operating, investing, or otherwise conducting business in the currencies of certain European countries that replace their national currencies with a single, multinational currency called the euro. These regulations provide rules relating to adjustments required for qualified business units operating in such currencies and rules relating to the tax effect of holding such currencies, or financial instruments or contracts denominated in such currencies.

DATES: *Effective Date:* These regulations are effective January 11, 2001.

Applicability Date: These regulations are applicable for tax years ending after July 29, 1998.

FOR FURTHER INFORMATION CONTACT: John W. Rogers III of the Office of Associate Chief Counsel (International), (202) 622–3870, regarding the change in functional currency rules and Thomas Preston of the Office of Assistant Chief Counsel (Financial Institutions and Products), (202) 622–3930, regarding section 1001 (not toll free calls).

SUPPLEMENTARY INFORMATION:

Background

On March 9, 1998, the IRS issued Announcement 98–18 (1998–9 IRB 44) requesting comments relating to the tax issues for U.S. taxpayers operating, investing, or otherwise conducting business in a currency that is converting to the euro. Numerous comments were received. After consideration of the comments, and in order to provide immediate guidance, the Treasury and the IRS published in the **Federal Register** temporary regulations (63 FR 40366) and a notice of proposed rulemaking by cross-reference to the temporary regulations (63 FR 40383) on July 29, 1998. No public hearing was held in conjunction with the notice of proposed rulemaking because no taxpayers requested to speak at the hearing.

In the notice of proposed rulemaking, the Treasury and The IRS requested comments with respect to certain additional issues. Two comments were received in connection with the request for comments and are discussed in greater detail below.

Explanation of Provisions and Discussion of Comments

The temporary regulations provide rules relating to U.S. taxpayers operating, investing, or otherwise conducting business in the currencies of countries that replace their national currencies (legacy currencies) with a single, multinational currency called the euro. Thus, a legacy currency would include former currencies of the eleven countries that adopted the euro in 1999 as well as the currency of a country after it adopts the euro at some later date. The temporary regulations generally provide guidance relating to the circumstances under which the euro conversion creates a realization event with respect to instruments and contracts denominated in a legacy currency, and the circumstances under which the euro conversion constitutes a change in functional currency for a qualified business unit (QBU or QBUs, as the case may be) whose functional currency is a legacy currency, and certain consequences thereof. The temporary regulations published in the **Federal Register** on July 29, 1998, are finalized substantially as proposed. See the preamble to the temporary regulations for an explanation of the provisions of those regulations.

As noted above, two comments were received in connection with the publication of the temporary regulations and the notice of proposed rulemaking. One comment addressed the effect of the euro conversion to a corporation that has significant numbers of legacy currency transactions but has a non-legacy currency as its functional currency. For example, a corporation may have a non-legacy currency as its functional currency because its economic environment reflected more significant activities denominated in such currency (*e.g.,* the U.S. dollar or the Swiss franc) relative to any single legacy currency. However, given the aggregation of the individual legacy currencies into the euro, the currency of the corporation's economic environment

in which a significant part of its activities are conducted is the euro. The commenter suggested that, in such circumstances, the corporation should be allowed to change its functional currency to the euro automatically.

In response to the comment, the regulation provides a new rule in which a QBU that uses a non-legacy currency as its functional currency may change its functional currency to the euro provided that the euro is a currency of the economic environment in which a significant part of the QBU's activities are conducted, the QBU maintains its books and records in the euro after conversion, and the QBU is not required to use the dollar as its functional currency. The change is deemed to be made with the consent of the Commissioner if the change is made within the period set forth in § 1.985–8(b)(2). A QBU changing its functional currency under this new rule is required to make the change in method of accounting adjustments under § 1.985–5. Treasury and the IRS believe that the rules of § 1.985–5 appropriately apply to this circumstance because the change in functional currency is not an involuntary change of the same nature as a QBU whose functional currency is a legacy currency.

The second comment suggested that the temporary regulations do not provide clear guidance in the case where, prior to conversion, the functional currency of a taxpayer and one of its QBU branches is the same legacy currency, and either the taxpayer or its QBU branch converts to the euro as its functional currency in a taxable year prior to the conversion of the other. The comment noted that the temporary regulations presume that the taxpayer and its branch have a different functional currency, but do not address instances where they have the same functional currency. The comment recommended that the regulations provide rules that require calculation of section 987 gain or loss during the period in which the taxpayer and its branch have different functional currencies. The recommendation is not adopted because section 987 currency gain or loss should not arise when a taxpayer and its branch use the same legacy currency as their functional currencies even if each adopts the euro as its functional currency in different years.

Finally, the notice of proposed rulemaking requested comments regarding the treatment of section 988 transactions that are held by euro functional currency QBUs and that are denominated in a currency that is replaced by the euro in the future. While no comments were received, Treasury and the IRS believe that rules relating to this issue should be clarified. Accordingly, § 1.985–8(d) provides that the principles of § 1.985–8(c)(3) apply in this context. Under this rule, legacy currency transactions generally continue to be treated as section 988 transactions and the principles of section 988 apply. Further, the principles provided in § 1.985–8(c)(3)(iii) and (iv) continue to apply to currency and accounts payable and receivable, respectively.

Special Analysis

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedures Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the final rule does not impose a collection of information on small entities, the provisions of the Regulatory Flexibility Act do not apply. Pursuant to section 7805(f) of the Internal Revenue Code, these regulations were submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

Drafting Information

The principal authors of these final regulations are John W. Rogers III of the Office of the Associate Chief Counsel (International) and Thomas Preston of the Office of Associate Chief Counsel (Financial Institutions and Products). Other personnel from the IRS and Treasury Department also participated in their development.

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and record keeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 1 is amended as follows:

PART 1—INCOME TAXES

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

Authority: 26 U.S.C. 7805 * * *

§ 1.985–1 [Amended]

Par. 2. In § 1.985–1, paragraph (c)(6), in the last sentence, the reference ''§ 1.985–8T'' is removed and ''§ 1.985–8'' is added in its place.

§ 1.985–4 [Amended]

Par. 3. In § 1.985–4, paragraph (a), in the last sentence, the reference ''§ 1.985–8T'' is removed and ''§ 1.985–8'' is added in its place.

Par. 4. Section 1.985–8 is added to read as follows:

§ 1.985–8 Special rules applicable to the European Monetary Union (conversion to euro).

(a) *Definitions*—(1) *Legacy currency.* A legacy currency is the former currency of a Member State of the European Community which is substituted for the euro in accordance with the Treaty establishing the European Community signed February 7, 1992. The term legacy currency shall also include the European Currency Unit.

(2) *Conversion rate.* The conversion rate is the rate at which the euro is substituted for a legacy currency.

(b) *Operative rules*—(1) *Initial adoption.* A QBU (as defined in § 1.989(a)–1(b)) whose first taxable year begins after the euro has been substituted for a legacy currency may not adopt a legacy currency as its functional currency.

(2) *QBU with a legacy currency as its functional currency*—(i) *Required change.* A QBU with a legacy currency as its functional currency is required to change its functional currency to the euro beginning the first day of the first taxable year—

(A) That begins on or after the day that the euro is substituted for that legacy currency (in accordance with the Treaty on European Union); and

(B) In which the QBU begins to maintain its books and records (as described in § 1.989(a)–1(d)) in the euro.

(ii) Notwithstanding paragraph (b)(2)(i) of this section, a QBU with a legacy currency as its functional currency is required to change its functional currency to the euro no later than the last taxable year beginning on or before the first day such legacy currency is no longer valid legal tender.

(3) Q*BU with a non-legacy currency as its functional currency* —(i) *In general.* A QBU with a non-legacy currency as its functional currency may change its functional currency to the euro pursuant to this § 1.985–8 if—

(A) Under the rules set forth in § 1.985–1(c), the euro is the currency of the economic environment in which a significant part of the QBU's activities are conducted;

(B) After conversion, the QBU maintains its books and records (as described in § 1.989(a)–1(d)) in the euro; and

(C) The QBU is not required to use the dollar as its functional currency under § 1.985–1(b).

(ii) *Time period for change.* A QBU with a non-legacy currency as its functional currency may change its functional currency to the euro under this section only if it does so within the period set forth in paragraph (b)(2) of this section as if the functional currency of the QBU was a legacy currency.

(4) *Consent of Commissioner.* A change made pursuant to paragraph (b) of this section shall be deemed to be made with the consent of the Commissioner for purposes of § 1.985–4. A QBU changing its functional currency to the euro pursuant to paragraph (b)(2) of this section must make adjustments as provided in paragraph (c) of this section. A QBU changing its functional currency to the euro pursuant to paragraph (b)(3) must make adjustments as provided in § 1.985–5.

(5) *Statement to file upon change.* With respect to a QBU that changes its functional currency to the euro under paragraph (b) of this section, an affected taxpayer shall attach to its return for the taxable year of change a statement that includes the following: ''TAXPAYER CERTIFIES THAT A QBU OF THE TAXPAYER HAS CHANGED ITS FUNCTIONAL CURRENCY TO THE EURO PURSUANT TO TREAS. REG. § 1.985–8.'' For purposes of this paragraph (b)(5), an affected taxpayer shall be in the case where the QBU is: a QBU of an individual U.S. resident (as a result of the activities of such individual), the individual; a QBU branch of a U.S. corporation, the corporation; a controlled foreign corporation (as described in section 957)(or QBU branch thereof), each United States shareholder (as described in section 951(b)); a partnership, each partner separately; a noncontrolled section 902 corporation (as described in section 904(d)(2)(E)) (or branch thereof), each domestic shareholder as described in § 1.902–1(a)(1); or a trust or estate, the fiduciary of such trust or estate.

(c) *Adjustments required when a QBU changes its functional currency from a legacy currency to the euro pursuant to paragraph (b)(2) of this section*—(1) *In general.* A QBU that changes its functional currency from a legacy currency to the euro pursuant to paragraph (b)(2) of this section must make the adjustments described in paragraphs (c)(2) through (5) of this section. Section 1.985–5 shall not apply.

(2) *Determining the euro basis of property and the euro amount of liabilities and other relevant items.* The euro basis in property and the euro amount of liabilities and other relevant items shall equal the product of the legacy functional currency adjusted basis or amount of liabilities multiplied by the applicable conversion rate.

(3) *Taking into account exchange gain or loss on legacy currency section 988 transactions*—(i) *In general.* Except as provided in paragraphs (c)(3)(iii) and (iv) of this section, a legacy currency denominated section 988 transaction (determined after applying section 988(d)) outstanding on the last day of the taxable year immediately prior to the year of change shall continue to be treated as a section 988 transaction after the change and the principles of section 988 shall apply.

(ii) *Examples.* The application of this paragraph (c)(3) may be illustrated by the following examples:

Example 1. X, a calendar year QBU on the cash method of accounting, uses the deutschmark as its functional currency. X is not described in section 1281(b). On July 1, 1998, X converts 10,000 deutschmarks (DM) into Dutch guilders (fl) at the spot rate of fl1 = DM1 and loans the 10,000 guilders to Y (an unrelated party) for one year at a rate of 10% with principal and interest to be paid on June 30, 1999. On January 1, 1999, X changes its functional currency to the euro pursuant to this section. Assume that the euro/deutschmark conversion rate is set by the European Council at 1= DM2. Assume further that the euro/guilder conversion rate is set at 1 = fl2.25. Accordingly, under the terms of the note, on June 30, 1999, X will receive 4444.44 (fl10,000/2.25) of principal and 444.44 (fl1,000/2.25) of interest. Pursuant to this paragraph (c)(3), X will realize an exchange loss on the principal computed under the principles of § 1.988–2(b)(5). For this purpose, the exchange rate used under § 1.988–2(b)(5)(i) shall be the guilder/euro conversion rate. The amount under § 1.988–2(b)(5)(ii) is determined by translating the fl10,000 at the guilder/deutschmark spot rate on July 1, 1998, and translating that deutschmark amount into euros at the deutschmark/euro conversion rate. Thus, X will compute an exchange loss for 1999 of 555.56 determined as follows: [4444.44 (fl10,000/2.25)–5000 ((fl10,000/1)/2) = – 555.56]. Pursuant to this paragraph (c)(3), the character and source of the loss are determined pursuant to section 988 and regulations thereunder. Because X uses the cash method of accounting for the interest on this debt instrument, X does not realize exchange gain or loss on the receipt of that interest.

Example 2. (i) X, a calendar year QBU on the accrual method of accounting, uses the deutschmark as its functional currency. On February 1, 1998, X converts 12,000 deutschmarks into Dutch guilders at the spot rate of fl1 = DM1 and loans the 12,000 guilders to Y (an unrelated party) for one year at a rate of 10% with principal and interest to be paid on January 31, 1999. In addition, assume the average rate (deutschmark/guilder) for the period from February 1, 1998, through December 31, 1998 is fl1.07 = DM1. Pursuant to § 1.988–2(b)(2)(ii)(C), X will accrue eleven months of interest on the note and recognize interest income of DM1028.04 (fl1100/1.07) in the 1998 taxable year.

(ii) On January 1, 1999, the euro will replace the deutschmark as the national currency of Germany pursuant to the Treaty on European Union signed February 7, 1992. Assume that on January 1, 1999, X changes its functional currency to the euro pursuant to this section. Assume that the euro/deutschmark conversion rate is set by the European Council at 1 = DM2. Assume further that the euro/guilder conversion rate is set at 1 = fl2.25. In 1999, X will accrue one month of interest equal to 44.44 (fl100/2.25). On January 31, 1999, pursuant to the note, X will receive interest denominated in euros of 533.33 (fl1200/2.25). Pursuant to this paragraph (c)(3), X will realize an exchange loss in the 1999 taxable year with respect to accrued interest computed under the principles of § 1.988–2(b)(3). For this purpose, the exchange rate used under § 1.988–2(b)(3)(i) is the guilder/euro conversion rate and the exchange rate used under § 1.988–2(b)(3)(ii) is the deutschmark/euro conversion rate. Thus, with respect to the interest accrued in 1998, X will realize exchange loss of 25.13 under § 1.988–2(b)(3) as follows: [488.89 (fl1100/2.25)– 514.02 (DM1028.04/2) =– 25.13]. With respect to the one month of interest accrued in 1999, X will realize no exchange gain or loss since the exchange rate when the interest accrued and the spot rate on the payment date are the same.

(iii) X will realize exchange loss of 666.67 on repayment of the loan principal computed in the same manner as in Example 1 [5333.33 (fl12,000/2.25)– 6000 fl12,000/1)/2)]. The losses with respect to accrued interest and principal are characterized and sourced under the rules of section 988.

(iii) *Special rule for legacy nonfunctional currency.* The QBU shall realize or otherwise take into account for all purposes of the Internal Revenue Code the amount of any unrealized exchange gain or loss attributable to nonfunctional currency (as described in section 988(c)(1)(C)(ii)) that is denominated in a legacy currency as if the currency were disposed of on the last day of the taxable year immediately prior to the year of change. The character and source of the gain or loss are determined under section 988.

(iv) *Legacy currency denominated accounts receivable and payable*—(A) *In general.* A QBU may elect to realize or otherwise take into account for all purposes of the Internal Revenue Code the amount of any unrealized exchange gain or loss attributable to a legacy currency denominated item described in section 988(c)(1)(B)(ii) as if the item were terminated on the last day of the taxable year ending prior to the year of change.

(B) *Time and manner of election.* With respect to a QBU that makes an

election described in paragraph (c)(3)(iv)(A) of this section, an affected taxpayer (as described in paragraph (b)(5) of this section) shall attach a statement to its tax return for the taxable year ending immediately prior to the year of change which includes the following: ''TAXPAYER CERTIFIES THAT A QBU OF THE TAXPAYER HAS ELECTED TO REALIZE CURRENCY GAIN OR LOSS ON LEGACY CURRENCY DENOMINATED ACCOUNTS RECEIVABLE AND PAYABLE UPON CHANGE OF FUNCTIONAL CURRENCY TO THE EURO.'' A QBU making the election must do so for all legacy currency denominated items described in section 988(c)(1)(B)(ii).

(4) *Adjustments when a branch changes its functional currency to the euro*—(i) *Branch changing from a legacy currency to the euro in a taxable year during which taxpayer's functional currency is other than the euro.* If a branch changes its functional currency from a legacy currency to the euro for a taxable year during which the taxpayer's functional currency is other than the euro, the branch's euro equity pool shall equal the product of the legacy currency amount of the equity pool multiplied by the applicable conversion rate. No adjustment to the basis pool is required.

(ii) *Branch changing from a legacy currency to the euro in a taxable year during which taxpayer's functional currency is the euro.* If a branch changes its functional currency from a legacy currency to the euro for a taxable year during which the taxpayer's functional currency is the euro, the taxpayer shall realize gain or loss attributable to the branch's equity pool under the principles of section 987, computed as if the branch terminated on the last day prior to the year of change. Adjustments under this paragraph (c)(4)(ii) shall be taken into account by the taxpayer ratably over four taxable years beginning with the taxable year of change.

(5) *Adjustments to a branch's accounts when a taxpayer changes to the euro*—(i) *Taxpayer changing from a legacy currency to the euro in a taxable year during which a branch's functional currency is other than the euro.* If a taxpayer changes its functional currency to the euro for a taxable year during which the functional currency of a branch of the taxpayer is other than the euro, the basis pool shall equal the product of the legacy currency amount of the basis pool multiplied by the applicable conversion rate. No adjustment to the equity pool is required.

(ii) *Taxpayer changing from a legacy currency to the euro in a taxable year during which a branch's functional currency is the euro.* If a taxpayer changes its functional currency from a legacy currency to the euro for a taxable year during which the functional currency of a branch of the taxpayer is the euro, the taxpayer shall take into account gain or loss as determined under paragraph (c)(4)(ii) of this section.

(6) *Additional adjustments that are necessary when a corporation changes its functional currency to the euro.* The amount of a corporation's euro currency earnings and profits and the amount of its euro paid-in capital shall equal the product of the legacy currency amounts of these items multiplied by the applicable conversion rate. The foreign income taxes and accumulated profits or deficits in accumulated profits of a foreign corporation that were maintained in foreign currency for purposes of section 902 and that are attributable to taxable years of the foreign corporation beginning before January 1, 1987, also shall be translated into the euro at the conversion rate.

(d) *Treatment of legacy currency section 988 transactions with respect to a QBU that has the euro as its functional currency*—(1) *In general.* This § 1.985–8(d) applies to a QBU that has the euro as its functional currency and that holds a section 988 transaction denominated in, or determined by reference to, a currency that is substituted by the euro. For example, this paragraph (d) will apply to a German QBU with the euro as its functional currency if the QBU is holding Country X currency or other section 988 transactions denominated in such currency on the day in the year 2005 when the euro is substituted for the Country X currency.

(2) *Principles of paragraph (c)(3) of this section shall apply.* With respect to a QBU described in paragraph (d) of this section, the principles of paragraph (c)(3) of this section shall apply. For example, if a German QBU with the euro as its functional currency is holding a Country X currency denominated debt instrument on the day in the year 2005 when the euro is substituted for the Country X currency, the instrument shall continue to be treated as a section 988 transaction pursuant to the principles of paragraph (c)(3)(i) of this section. However, if such QBU holds Country X currency, the QBU shall take into account any unrealized exchange gain or loss pursuant to the principles of paragraph (c)(3)(iii) of this section as if the currency was disposed of on the day prior to the day the euro is substituted for the Country X currency. Similarly, if the QBU makes an election under the principles of paragraph (c)(3)(iv) of this section, the QBU shall take into account for all purposes of the Internal Revenue Code the amount of any unrealized exchange gain or loss attributable to a legacy currency denominated item described in section 988(c)(1)(B)(ii) as if the item were terminated on the day prior to the day the euro is substituted for the Country X currency.

(e) *Effective date.* This section applies to tax years ending after July 29, 1998.

§ 1.985–8T [Removed]

Par. 5. Section 1.985–8T is removed.

Par. 6. Section 1.1001–5 is added to read as follows:

§ 1.1001–5 European Monetary Union (conversion to the euro).

(a) *Conversion of currencies.* For purposes of § 1.1001–1(a), the conversion to the euro of legacy currencies (as defined in § 1.985–8(a)(1)) is not the exchange of property for other property differing materially in kind or extent.

(b) *Effect of currency conversion on other rights and obligations.* For purposes of § 1.1001–1(a), if, solely as the result of the conversion of legacy currencies to the euro, rights or obligations denominated in a legacy currency become rights or obligations denominated in the euro, that event is not the exchange of property for other property differing materially in kind or extent. Thus, for example, when a debt instrument that requires payments of amounts denominated in a legacy currency becomes a debt instrument requiring payments of euros, that alteration is not a modification within the meaning of § 1.1001–3(c).

(c) *Effective date.* This section applies to tax years ending after July 29, 1998.

§ 1.1001–5T [Removed]

Par. 7. Section 1.1001–5T is removed.

Approved: December 13, 2000.

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 602

[TD 8929]

RIN 1545–AQ30

Accounting for Long-Term Contracts

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations describing how income from a long-term contract must be accounted for under section 460 of the Internal Revenue Code, which was enacted by the Tax Reform Act of 1986. A taxpayer manufacturing or constructing property under a long-term contract will be affected by these regulations.

DATES: *Effective Date:* These regulations are effective on January 11, 2001.

Applicability Date: These regulations apply to any contract entered into on or after January 11, 2001.

FOR FURTHER INFORMATION CONTACT: Leo F. Nolan II or John M. Aramburu of the Office of Associate Chief Counsel (Income Tax and Accounting) at (202) 622–4960 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1545–1650. Responses to this collection of information are mandatory.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

The estimated annual burden per respondent and/or recordkeeper is 15 minutes.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224, and to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503.

Books or records relating to a collection of information must be retained as long as their contents might become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

Section 460, which was enacted by section 804 of the Tax Reform Act of 1986, Public Law 99–514 (100 Stat. 2085, 2358–2361), generally requires a taxpayer to determine the taxable income from a long-term contract using the percentage-of-completion method. Section 460 was amended by section 10203 of the Omnibus Budget Reconciliation Act of 1987, Public Law 100–203 (101 Stat. 1330, 1330–394); by sections 1008(c) and 5041 of the Technical and Miscellaneous Revenue Act of 1988, Public Law 100–647 (102 Stat. 3342, 3438–3439 and 3673–3676); by sections 7621 and 7811(e) of the Omnibus Budget Reconciliation Act of 1989, Public Law 101–239 (103 Stat. 2106, 2375–2377 and 2408–2409); by section 11812 of the Omnibus Budget Reconciliation Act of 1990, Public Law 101–508 (104 Stat. 1388, 1388–534 to 1388-536); by sections 1702(h)(15) and 1704(t)(28) of the Small Business Job Protection Act of 1996, Public Law 104–188 (110 Stat. 1755, 1874, 1888); and by section 1211 of the Taxpayer Relief Act of 1997, Public Law 105–34 (111 Stat. 788, 998–1000).

Section 460(h) directs the Secretary to prescribe regulations to the extent necessary or appropriate to carry out the purpose of section 460, including regulations to prevent a taxpayer from avoiding section 460 by using related parties, pass-through entities, intermediaries, options, and other similar arrangements.

On May 5, 1999, the IRS and Treasury Department published a notice of proposed rulemaking (64 FR 24096 [REG–208156–91, 1999–22 I.R.B. 11]) relating to section 460. Comments responding to the notice were received, and a public hearing was scheduled for September 14, 1999.

The IRS and Treasury Department received eleven comment letters concerning the notice of proposed rulemaking. After considering the comments contained in these letters, the IRS and Treasury Department adopt the proposed regulations as revised by this Treasury decision. The comments and revisions are discussed below.

Explanation of Provisions

1. Overview

Section 460 generally requires the income from a long-term contract to be determined using the percentage-of-completion method based on a cost-to-cost comparison (PCM). However, the income from exempt construction contracts still may be determined using the completed-contract method (CCM), the exempt-contract percentage-of-completion method (EPCM), or any other permissible method. Contracts that are not long-term contracts must be accounted for using a permissible method of accounting other than a long-term contract method (*i.e.,* a method other than the PCM, the CCM, or the EPCM). See section 446 and the regulations thereunder.

One commentator suggested that the exceptions to the mandatory use of the PCM included in the proposed regulations be expanded to include ''any portion of the long-term manufacturing contract for which no payment for the manufacture of the subject matter of the contract is required to be made before the manufacture of the item is completed.'' The exceptions contained in the proposed regulations were specifically provided by the statute and the statute does not include the suggestion made by the commentator. Thus, the IRS and Treasury Department did not adopt this suggestion.

2. Definition of Long-Term Contract

Under section 460(f), ''long-term contract'' generally means any contract for the building, installation, construction (construction), or the manufacture, of property if the contract is not completed within the taxable year the taxpayer enters into the contract (contracting year). However, a manufacturing contract is not a long-term contract unless it involves the manufacture of (1) a unique item of a type that is not normally included in the finished goods inventory of the taxpayer or (2) an item normally requiring more than 12 calendar months to complete, regardless of the duration of the contract.

Continuing the policy established in Notice 89–15 (1989–1 C.B. 634), the proposed regulations provide that it is not relevant whether the customer has title to, control over, or risk of loss with respect to the property. One commentator suggested that the final regulations should not retain the rule that requires a contractor to ignore title and risk-of-loss issues relative to the applicability of section 460 because a contractor has little freedom to restructure a contract to ''construct'' into a contract to ''sell.'' The IRS and Treasury Department did not adopt this suggestion because we believe that a contract's classification should be based on the performance required of the taxpayer under the contract regardless

of whether that contract otherwise would be classified as a sales contract or a construction or manufacturing contract. Moreover, the IRS and Treasury Department continue to believe that the rule in the proposed regulations is necessary to prevent a taxpayer from circumventing section 460 by structuring a construction contract to resemble a sales contract without changing the taxpayer's obligations under the contract. Another commentator asked whether a contract is subject to section 460 if it requires the taxpayer to manufacture or construct property in order to fulfill its contractual obligation but the property is never delivered to the customer (*e.g.*, a research contract for test results). Again, the IRS and Treasury Department believe that a contract's classification should depend upon the performance required of the taxpayer under the contract. Thus, the final regulations clarify that it is irrelevant whether title in the property manufactured or constructed under the contract is delivered to the customer.

The proposed regulations provide that a contract is not a construction contract if it requires the taxpayer to provide land to the customer and the estimated total allocable contract costs attributable to the taxpayer's construction activities are less than 10 percent of the contract's total contract price. One commentator asked for clarification concerning whether the estimated total allocable contract costs attributable to the taxpayer's construction activities includes the cost of the land provided under the contract. The final regulations clarify that the cost of this land is not an allocable contract cost when the taxpayer determines whether the cost of its construction activities is less than 10 percent of the contract's total contract price.

3. Date Taxpayer Completes a Long-Term Contract

The proposed regulations provide that a long-term contract is completed in the earlier taxable year (completion year) that: (1) The customer uses the subject matter of the contract (other than for testing) and at least 95 percent of the total allocable contract costs attributable to the subject matter have been incurred by the taxpayer; or (2) the subject matter of the contract is finally completed and accepted. To the extent that the ''customer-use'' rule requires a taxpayer to treat a contract as completed before final completion and acceptance have occurred, the proposed regulations explicitly adopt a rule different from that considered in *Ball, Ball and Brosamer, Inc.* v. *Commissioner,* 964 F.2d 890 (9th Cir. 1992), *aff'g* T.C. Memo. 1990–454.

Some commentators argued against having a rule that will declare a contract completed earlier than under the finally-completed-and-accepted standard illustrated in *Ball.* Some commentators also argued that the customer-use rule is confusing to subcontractors because it is unclear whether a subcontractor's ''customer'' is the general, or ''prime,'' contractor or the ultimate owner of the property. On the other hand, one commentator asked for a bright-line standard for completion and suggested, among other possibilities, that completion occur when 95 percent of the estimated costs have been incurred.

The IRS and Treasury Department continue to believe that a contract is complete for all practical purposes when the customer uses the subject matter of that contract and the taxpayer has only five percent or less of the total allocable contract costs remaining to be incurred. Delaying a contract's completion beyond this point, as the Tax Court permitted in *Ball,* does not reflect the substance of the transaction and could encourage the use of formalities to delay a contract's completion unreasonably. Thus, the final regulations do not substantively change the customer-use rule contained in the proposed regulations. However, the final regulations clarify that a subcontractor's customer is the general contractor.

Several commentators expressed concern that the customer-use rule contained in the proposed regulations will create additional administrative burdens for taxpayers using the PCM because they often will have to apply the look-back method two times, first upon customer use and again upon final completion and acceptance. Though the IRS and Treasury Department believe that the customer-use rule results in an appropriate determination of completion, we understand these concerns. Thus, to simplify a taxpayer's reporting requirements under the look-back method, the IRS and Treasury Department have modified the look-back regulations to require a taxpayer to delay the first application of the look-back method until the taxable year in which a long-term contract is finally completed and accepted.

4. Severing and Aggregating Contracts

The proposed regulations allow the Commissioner, and generally require a taxpayer, to sever and aggregate contracts when necessary to clearly reflect income. The proposed regulations provide the following criteria for determining whether severance or aggregation is required: Independent versus interdependent pricing, separate delivery or acceptance, and the reasonable businessperson standard. However, under the proposed regulations, a taxpayer may not sever a contract subject to the PCM. In addition, the proposed regulations require a taxpayer to notify the Commissioner when severing a long-term contract not accounted for using the PCM and provide agreement-specific information, including the criteria for severing or aggregating the agreement.

Some commentators criticized the ''no severance'' rule for long-term contracts subject to the PCM. The ''no severance'' rule is provided in the proposed regulations because the IRS and Treasury Department believe that in most cases, a taxpayer's use of the PCM and look-back method will clearly reflect the taxpayer's income from a long-term contract. To date, the only identified reason to allow severance of a contract subject to the PCM related to the application of the 10-percent method as shown in § 1.460–1(j) *Example 8* of the proposed income tax regulations. Conversely, the IRS and Treasury Department believe that permitting a taxpayer to sever a contract subject to the PCM could allow the taxpayer to manipulate taxable income (*e.g.,* by severing to create a loss contract and accelerate the loss) or to avoid the application of section 460 (*e.g.,* by ''completing'' the contract during the contracting year). Nonetheless, the IRS and Treasury Department agree with the commentators' concerns that to the extent severance is necessary to clearly reflect income from a long-term contract (*e.g.,* due to the application of the 10-percent method), it should be permitted. Accordingly, the final regulations allow a taxpayer to sever a long-term contract if necessary to clearly reflect income, but only if the taxpayer has obtained the Commissioner's prior written consent.

Some commentators criticized the notification requirement for severed and aggregated contracts as being unduly burdensome. The IRS and Treasury Department continue to believe that notification will help taxpayers and the IRS consistently apply the severing and aggregating rules. In recognition of the potential burden associated with the proposed notification requirement, however, the final regulations simplify the notification by only requiring that a taxpayer inform the IRS when it has severed or aggregated agreements. Thus, the taxpayer is no longer required to provide agreement-specific information.

One commentator suggested that the reasonable businessperson standard be

eliminated because it is merely a subset of independent pricing and interdependent pricing (the pricing standards), which should be the primary criteria for determining whether long-term contracts must be severed or aggregated to clearly reflect income. The IRS and Treasury Department agree that the pricing standards and the reasonable businessperson standard overlap, but believe that the pricing standard is a subset of the reasonable businessperson standard. Besides requiring an analysis of pricing, the reasonable businessperson standard requires an analysis of all the facts and circumstances of the business arrangement between the taxpayer and the customer. Thus, because the absence of the reasonable businessperson standard might change the decision to sever or aggregate in some cases, the final regulations retain this criterion and clarify its distinction from the pricing standards.

5. Hybrid Contracts

Under the proposed regulations, a taxpayer generally must classify a contract that requires the taxpayer to manufacture personal property and to construct real property (hybrid contract) as separate manufacturing and construction contracts. If at least 95 percent of the estimated allocable contract costs are reasonably allocable to manufacturing (or construction) activities, the taxpayer may classify the contract as a manufacturing (or construction) contract.

One commentator suggested that the final regulations allow a taxpayer to elect to use the PCM to account for a hybrid contract instead of requiring the taxpayer to account for both parts separately. The IRS and Treasury Department agree with the commentator's request for simplification. Accordingly, the final regulations allow a taxpayer to elect, on a contract-by-contract basis, to classify a hybrid contract as a long-term manufacturing contract subject to the PCM. In addition, because this election effectively supersedes the 95-percent election that would have applied to hybrid contracts that are primarily manufacturing contracts, the final regulations retain the 95-percent election as a second election that applies only to hybrid contracts that are primarily construction contracts.

6. Contracts of Related Parties

The proposed regulations provide that if a related party and its customer enter into a long-term contract subject to the PCM, and a taxpayer performs any activity that is incident to or necessary for the related party's long-term contract, the taxpayer must account for the gross receipts and costs attributable to the activity using the PCM. However, the proposed regulations contain an inventory exception for components and subassemblies produced by the taxpayer if the taxpayer regularly carries these items in its finished goods inventories and 80 percent or more of the gross receipts from the sale of these items typically comes from unrelated parties.

One commentator suggested that the percentage threshold be lowered from 80 percent to 50 percent and that the exception not be limited to items regularly carried in the taxpayer's finished goods inventories. The IRS and Treasury Department included the related party rule, originally promulgated in Notice 89–15, in the proposed regulations to prevent taxpayers from establishing special-purpose subsidiaries to avoid the application of section 460. However, in recognition that a related party that sells most units of a manufactured item to unrelated parties was not established for the purpose of avoiding section 460, the IRS and Treasury Department added the inventory exception to the proposed regulations to reduce the related party's accounting burden. The IRS and Treasury Department agree, however, that the inventory exception is too narrow. Accordingly, the final regulations lower the percentage threshold from ''80 percent or more'' to ''more than 50 percent'' and eliminate the requirement that the components or subassemblies be carried in finished goods inventories.

7. Unique Items

Section 460 applies if a taxpayer manufactures a unique item of a type that is not normally included in the finished goods inventory of the taxpayer and if the contract is not completed by the close of the contracting year. The proposed regulations provide that ''unique'' means specifically designed for the needs of a customer. In addition, the proposed regulations contain three safe harbors concerning contracts to manufacture unique items. First, an item is not unique if the taxpayer normally completes the item within 90 days. Second, an item is not unique if the total allocable contract costs attributable to customizing activities that are incident to or necessary for the production of the item do not exceed 5 percent of the estimated total costs allocable to the item. Third, a unique item ceases to be unique no later than when the taxpayer normally includes similar items in its finished goods inventory. For an item that does not satisfy one of these three safe harbors, the determination of whether the item is unique is based on the facts and circumstances.

Some commentators suggested that the final regulations contain either a 140-day or a 180-day safe harbor instead of the 90-day safe harbor. The IRS and Treasury Department did not adopt these suggestions because we believe that a 90-day safe harbor appropriately limits the meaning of ''unique'' in most cases. However, the IRS and Treasury Department have modified the 90-day safe harbor to clarify that in the case of a contract to manufacture multiple units of the same item, the 90-day safe harbor applies only if each unit normally is completed within 90 days.

Some commentators suggested that the final regulations contain either a 10-percent, 15-percent, or 20-percent safe harbor instead of the 5-percent safe harbor. In particular, these commentators stated that a 5-percent safe harbor will not alleviate any controversy between taxpayers and revenue agents because revenue agents generally do not raise the issue of unique items if the taxpayer's customizing costs do not exceed 5 percent. The IRS and Treasury Department agree that it is reasonable to assume that an item is not unique if the taxpayer's customizing costs do not exceed 10 percent. Thus, the customization safe harbor in the final regulations has been increased to 10 percent.

One commentator suggested that the cost of a taxpayer's customizing activities should not include the cost of any customized equipment purchased by a taxpayer from an unrelated party under a ''special accommodation'' arrangement with the customer that requires the taxpayer to acquire and install that customized equipment. The IRS and Treasury Department did not adopt this suggestion because such a special accommodation rule could enable taxpayers to avoid section 460 by having some long-term contract activities performed by outside parties.

Several commentators questioned the relevance of the ''basic design'' concept included in § 1.460–2(e) *Example 1* of the proposed regulations. To determine whether an item is unique, the relevant analysis is whether an item is customized (or manufactured according to a customer's specifications) regardless of whether the item is customized from a basic design. Accordingly, the final regulations delete the reference to the taxpayer's basic design in the example to eliminate any confusion.

One commentator questioned how the safe harbor applies in the case of a contract to manufacture multiple units of the same item. The IRS and Treasury Department believe that if significant customization is necessary to produce an item for a customer under the contract, that item is specifically designed for the needs of the customer, and thus is a unique item, regardless of the number of units produced for the customer under the contract. Thus, the final regulations clarify that for the purposes of applying the 10-percent safe harbor to a contract to manufacture multiple units of the same item, a taxpayer must allocate all customization costs to the first unit manufactured under the contract.

Some commentators suggested the addition of a fourth safe harbor that would exclude ''income on contracts for which progress payments have not been received by year end.'' The IRS and Treasury Department did not adopt this suggestion because we do not believe that such a rule bears any relationship to a determination of the uniqueness of an item and because such a rule is inconsistent with the statute.

8. 12-Month Completion Period

The proposed regulations provide that a manufactured item normally requires more than 12 months to complete if its ''production period,'' as defined in § 1.263A–12, is reasonably expected to exceed 12 months, determined at the end of the contracting year. In general, the production period for an item or unit begins when the taxpayer incurs at least 5 percent of the estimated total allocable contract costs, including planning and design expenditures, allocable to the item or unit, and the production period ends when the item or unit is ready for shipment to the taxpayer's customer.

Some commentators suggested that the final regulations be clarified to provide that ''normal time to complete'' includes only the time of physical production activity and not the time of any research, development, planning, or design activity. The IRS and Treasury Department did not adopt this suggestion because we believe that the definition of ''production period'' under § 1.263A–12(c)(3), which includes the time required for planning and design activity, is consistent with the allocation of costs to extended-period long-term contracts under § 1.451–3(d)(6) and with section 460(c)(1), which requires that costs be allocated under the rules applicable to extended-period long-term contracts. In addition, if an item manufactured under a long-term contract requires a significant amount of design time to produce, it is appropriate to include the time needed to perform these activities when determining that item's ''normal time to complete'' because these activities are directly attributable to that contract and are necessary to manufacture the subject matter of the contract. However, the final regulations clarify that a taxpayer is not required to consider activities related to costs that are not allocable contract costs under section 460 (*e.g.*, independent research and development expenses, marketing expenses) when determining the item's normal time to complete.

Some commentators asked how the 12-month rule applies in the case of a contract to manufacture multiple units of the same item. The final regulations clarify, that for the purposes of applying the 12-month rule to this type of contract, the time required to design and manufacture the first unit generally does not reflect the item's ''normal time to complete.'' For example, the time required to design the first unit of an item should not be considered as time required to manufacture subsequent identical units. The final regulations also include an example illustrating the determination of normal time to complete an item in the case of a contract to manufacture multiple units of the same item.

9. Percentage-of-Completion Method

The proposed regulations provide that, under the PCM, a taxpayer generally includes a portion of the total contract price in income for each taxable year that the taxpayer incurs contract costs allocable to the long-term contract. Under the proposed regulations, total contract price included all bonuses, awards, and incentive payments if it is reasonably estimated that they will be received, even if the all events test has not yet been met. If, by the end of the completion year, a taxpayer cannot reasonably estimate whether a contingency will be satisfied, the bonus, award, or incentive payment is not includible in total contract price.

Some commentators argued that a taxpayer should not have to include contingent compensation in ''total contract price'' until the all events test for the item has been satisfied. The IRS and Treasury Department did not adopt this suggestion because the all events test is a judicially created test applying to taxpayers using an accrual method. *U.S.* v. *Anderson*, 269 U.S. 422 (1926). Conversely, section 460 is a self-contained, statutorily created accounting method that requires taxpayers to use estimated amounts when computing taxable income under the PCM and to use actual amounts when applying the look-back method. In addition, using the most accurate estimate of total contract price and total contract costs will produce the most accurate annual reporting of income and costs and will minimize discrepancies that could necessitate paying look-back interest. See *Tutor-Saliba Corp.* v. *Commissioner*, 115 T.C. No. 1 (July 17, 2000). However, in response to comments and questions concerning the contingent income rule, the final regulations provide that contingent income is includible in total contract price not later than when it is included in income for financial reporting purposes under generally accepted accounting principles.

One commentator suggested that the final regulations incorporate the rule under § 1.451–3(a)(1) that allows a taxpayer to account for long-term contracts of less-than-substantial duration using a method of accounting other than a long-term contract method of accounting. The IRS and Treasury Department did not adopt this suggestion because such a rule would be inconsistent with the statutory definition of ''long-term contract.''

One commentator asked how a contractor should account for the subject matter of a long-term contract when the customer breaches that contract before the contractor has transferred title to the customer but after the contractor has reported taxable income from that contract under the PCM (*e.g.*, unfinished condominium unit). In response to this comment, the final regulations include new § 1.460–4(b)(7), which provides that if a long-term contract is terminated before completion and, as a result, the taxpayer retains ownership of the property that is the subject matter of that contract, the taxpayer must reverse the previously reported gross income (loss) from the transaction in the taxable year of termination. As a result of reversing its previously reported gross income under this rule, a taxpayer generally will have an adjusted basis in the retained property equal to its previously deducted allocable contract costs. The look-back method does not apply to any terminated contract to the extent it is subject to this rule. The IRS and Treasury Department request suggestions for rules that will apply when the customer acquires ownership of some, but not all, of the property that is the subject matter of the contract.

10. Cost Allocation Rules

The proposed and final regulations provide that a taxpayer generally must

allocate costs to a contract subject to section 460(a) in the same manner as direct and indirect costs are capitalized to property produced by a taxpayer under section 263A. The regulations provide exceptions, however, that reflect the differences in the cost allocation rules of sections 263A and 460.

One commentator argued that the final regulations should contain a single standard for determining when the cost of a direct material is allocable to a long-term contract. In response to this comment, the final regulations contain a single standard linked to the uniform capitalization (UNICAP) rules of section 263A. The final regulations also clarify that, among other methods, a taxpayer dedicates direct materials by associating them with a specific contract (*e.g.*, by purchase order, entry on books and records, shipping instructions).

One commentator suggested that the final regulations clarify that taxpayers should not treat software development and software implementation costs as customization costs for the purposes of the proposed 5-percent safe harbor. The IRS and Treasury Department did not adopt this suggestion because we believe that software costs are allocable contract costs (and thus customization costs) to the extent they are incident to or necessary for the manufacture of the subject matter of the contract.

This commentator also suggested that the final regulations clarify that taxpayers should not treat guarantee, warranty, and maintenance costs as customization costs for the purposes of the proposed 5-percent safe harbor. The IRS and Treasury Department modified § 1.460–1(d)(2) to clarify that these types of costs are not allocable contract costs.

11. Simplified Cost-to-Cost Method

The proposed regulations generally permit a taxpayer to elect to allocate contract costs using the simplified cost-to-cost method. Under the simplified cost-to-cost method, a taxpayer must determine a contract's completion factor based upon only direct material costs; direct labor costs; and depreciation, amortization, and cost recovery allowances on equipment and facilities directly used to manufacture or construct property under the contract.

One commentator suggested that the final regulations clarify whether a taxpayer using the simplified cost-to-cost method is allowed or required to include subcontracted costs in a contract's completion factor. In response to this comment, the final regulations clarify that subcontracted costs represent either direct material or direct labor costs and thus must be allocated to a contract under the simplified cost-to-cost method when incurred under § 1.461–4(d)(2)(ii). In addition, a taxpayer must allocate subcontracted costs for all section 460 purposes (*e.g.*, applying the 10-percent safe harbor under § 1.460–2(b)(2)(ii)).

12. Statute of Limitations and Compound Interest on Look-Back Interest

One commentator requested guidance concerning the statute of limitations applicable to payments of, and claims for, look-back interest. The final regulations amend § 1.460–6(f)(1) and (2) to clarify the reporting requirements and add new § 1.460–6(f)(3). New § 1.460–6(f)(3) provides guidance on the statute of limitations applicable to the assessment and collection of look-back interest owed by a taxpayer. In addition, new § 1.460–6(f)(3) provides that a taxpayer's claim for credit or refund of look-back interest previously paid by or collected from the taxpayer is a claim for credit or refund of an overpayment of tax for federal income tax purposes, which is subject to the section 6511 statute of limitations. In contrast, new § 1.460–6(f)(3) provides that a taxpayer's claim for look-back interest (or interest payable on look-back interest) that is not attributable to an amount previously paid by or collected from the taxpayer is a general claim against the federal government, which is subject to the statutes of limitations found in 28 U.S.C. sections 2401 and 2501.

13. Effective Date

These final regulations apply to any contract entered into on or after January 11, 2001.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. Pursuant to section 7805(f) of the Internal Revenue Code, this Treasury decision was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business. It is hereby certified that the collection of information in this Treasury decision will not have a significant economic impact on a substantial number of small entities. The regulations require a taxpayer to attach a statement to its original federal income tax return if the taxpayer severs or aggregates a long-term contract. The statement is needed so the Commissioner can determine whether the taxpayer properly severed or aggregated the contract. It is uncommon for a taxpayer that has a long-term contract to sever or aggregate that contract. In addition, if a contract is severed or aggregated and a statement is required, it is estimated that it will, on average, require only 15 minutes to complete.

Drafting Information

The principal author of these regulations is Leo F. Nolan II, Office of Associate Chief Counsel (Income Tax and Accounting). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation is amended by removing the entry for ''Section 1.451–3 and 1.451–5'', revising the entry for ''Section 1.460–4'', and adding the following entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

* * * * *

Section 1.451–5 also issued under 96 Stat. 324, 493.

* * * * *

Section 1.460–1 also issued under 26 U.S.C. 460(h).

Section 1.460–2 also issued under 26 U.S.C. 460(h).

Section 1.460–3 also issued under 26 U.S.C. 460(h).

Section 1.460–4 also issued under 26 U.S.C. 460(h) and 1502.

Section 1.460–5 also issued under 26 U.S.C. 460(h).

* * * * *

§ 1.446–1 [Amended]

Par. 2. Section 1.446–1 is amended as follows:

1. In the second sentence of paragraph (c)(1)(iii), the language ''451'' is removed and ''460'' is added in its place.

2. In the fourth sentence of paragraph (e)(2)(ii)(*a*), the language ''§ 1.451–3'' is

removed and ''§ 1.460–4'' is added in its place.

§ 1.451–3 [Removed]

Par. 3. Section 1.451–3 is removed.

§ 1.451–5 [Amended]

Par. 4. Section 1.451–5 is amended by removing the language ''§ 1.451–3'' and adding ''§ 1.460–4'' in its place in the first sentence of paragraph (b)(3).

Par. 5. Section 1.460–0 is amended by:

1. Revising the introductory text.
2. Revising the entries for §§ 1.460–1 through 1.460–3, 1.460–4(a) through (i), and 1.460–5.
3. Adding an entry for § 1.460–4(k).
4. Removing the entry for § 1.460–6(c)(4)(iv).
5. Adding an entry for § 1.460–6(f)(3).
6. Removing the entries for §§ 1.460–7 and 1.460–8.

The revisions and addition read as follows:

§ 1.460–0 Outline of regulations under section 460.

This section lists the paragraphs contained in § 1.460–1 through § 1.460–6.

§ 1.460–1 Long-term contracts.

(a) Overview.
(1) In general.
(2) Exceptions to required use of PCM.
(i) Exempt construction contract.
(ii) Qualified ship or residential construction contract.
(b) Terms.
(1) Long-term contract.
(2) Contract for the manufacture, building, installation, or construction of property.
(i) In general.
(ii) De minimis construction activities.
(3) Allocable contract costs.
(4) Related party.
(5) Contracting year.
(6) Completion year.
(7) Contract commencement date.
(8) Incurred.
(9) Independent research and development expenses.
(10) Long-term contract methods of accounting.
(c) Entering into and completing long-term contracts.
(1) In general.
(2) Date contract entered into.
(i) In general.
(ii) Options and change orders.
(3) Date contract completed.
(i) In general.
(ii) Secondary items.
(iii) Subcontracts.
(iv) Final completion and acceptance.
(A) In general.
(B) Contingent compensation.
(C) Assembly or installation.
(D) Disputes.
(d) Allocation among activities.
(1) In general.
(2) Non-long-term contract activity.
(e) Severing and aggregating contracts.
(1) In general.
(2) Facts and circumstances.
(i) Pricing.
(ii) Separate delivery or acceptance.
(iii) Reasonable businessperson.
(3) Exceptions.
(i) Severance for PCM.
(ii) Options and change orders.
(4) Statement with return.
(f) Classifying contracts.
(1) In general.
(2) Hybrid contracts.
(i) In general.
(ii) Elections.
(3) Method of accounting.
(4) Use of estimates.
(i) Estimating length of contract.
(ii) Estimating allocable contract costs.
(g) Special rules for activities benefitting long-term contracts of a related party.
(1) Related party use of PCM.
(i) In general.
(ii) Exception for components and subassemblies.
(2) Total contract price.
(3) Completion factor.
(h) Effective date.
(1) In general.
(2) Change in method of accounting.
(i) [Reserved]
(j) Examples.

§ 1.460–2 Long-term manufacturing contracts.

(a) In general.
(b) Unique.
(1) In general.
(2) Safe harbors.
(i) Short production period.
(ii) Customized item.
(iii) Inventoried item.
(c) Normal time to complete.
(1) In general.
(2) Production by related parties.
(d) Qualified ship contracts.
(e) Examples.

§ 1.460–3 Long-term construction contracts.

(a) In general.
(b) Exempt construction contracts.
(1) In general.
(2) Home construction contract.
(i) In general.
(ii) Townhouses and rowhouses.
(iii) Common improvements.
(iv) Mixed use costs.
(3) $10,000,000 gross receipts test.
(i) In general.
(ii) Single employer.
(iii) Attribution of gross receipts.
(c) Residential construction contracts.

§ 1.460–4 Methods of accounting for long-term contracts.

(a) Overview.
(b) Percentage-of-completion method.
(1) In general.
(2) Computations.
(3) Post-completion-year income.
(4) Total contract price.
(i) In general.
(A) Definition.
(B) Contingent compensation.
(C) Non-long-term contract activities.
(ii) Estimating total contract price.
(5) Completion factor.
(i) Allocable contract costs.
(ii) Cumulative allocable contract costs.
(iii) Estimating total allocable contract costs.
(iv) Pre-contracting-year costs.
(v) Post-completion-year costs.
(6) 10-percent method.
(i) In general.
(ii) Election.
(7) Terminated contract.
(i) Reversal of income.
(ii) Adjusted basis.
(iii) Look-back method.
(c) Exempt contract methods.
(1) In general.
(2) Exempt-contract percentage-of-completion method.
(i) In general.
(ii) Determination of work performed.
(d) Completed-contract method.
(1) In general.
(2) Post-completion-year income and costs.
(3) Gross contract price.
(4) Contracts with disputed claims.
(i) In general.
(ii) Taxpayer assured of profit or loss.
(iii) Taxpayer unable to determine profit or loss.
(iv) Dispute resolved.
(e) Percentage-of-completion/capitalized-cost method.
(f) Alternative minimum taxable income.
(1) In general.
(2) Election to use regular completion factors.
(g) Method of accounting.
(h) Examples.
(i) [Reserved]

* * * * *

(k) Mid-contract change in taxpayer [Reserved]

§ 1.460–5 Cost allocation rules.

(a) Overview.
(b) Cost allocation method for contracts subject to PCM.
(1) In general.
(2) Special rules.
(i) Direct material costs.
(ii) Components and subassemblies.
(iii) Simplified production methods.
(iv) Costs identified under cost-plus long-term contracts and federal long-term contracts.
(v) Interest.
(A) In general.
(B) Production period.
(C) Application of section 263A(f).
(vi) Research and experimental expenses.
(vii) Service costs.
(A) Simplified service cost method.
(*1*) In general.
(*2*) Example.
(B) Jobsite costs.
(C) Limitation on other reasonable cost allocation methods.
(c) Simplified cost-to-cost method for contracts subject to the PCM.
(1) In general.
(2) Election.
(d) Cost allocation rules for exempt construction contracts reported using CCM.
(1) In general.
(2) Indirect costs.
(i) Indirect costs allocable to exempt construction contracts.

(ii) Indirect costs not allocable to exempt construction contracts.
(3) Large homebuilders.
(e) Cost allocation rules for contracts subject to the PCCM.
(f) Special rules applicable to costs allocated under this section.
(1) Nondeductible costs.
(2) Costs incurred for non-long-term contract activities.
(g) Method of accounting.

§ 1.460–6 Look-back method.

* * * * *

(f) * * *

(3) Statutes of limitations and compounding of interest on look-back interest.

* * * * *

Par. 6. Sections 1.460–1 through 1.460–3 are revised to read as follows:

§ 1.460–1 Long-term contracts.

(a) *Overview*—(1) *In general.* This section provides rules for determining whether a contract for the manufacture, building, installation, or construction of property is a long-term contract under section 460 and what activities must be accounted for as a single long-term contract. Specific rules for long-term manufacturing and construction contracts are provided in §§ 1.460–2 and 1.460–3, respectively. A taxpayer generally must determine the income from a long-term contract using the percentage-of-completion method described in § 1.460–4(b) (PCM) and the cost allocation rules described in § 1.460–5(b) or (c). In addition, after a contract subject to the PCM is completed, a taxpayer generally must apply the look-back method described in § 1.460-6 to determine the amount of interest owed on any hypothetical underpayment of tax, or earned on any hypothetical overpayment of tax, attributable to accounting for the long-term contract under the PCM.

(2) *Exceptions to required use of PCM*—(i) *Exempt construction contract.* The requirement to use the PCM does not apply to any exempt construction contract described in § 1.460–3(b). Thus, a taxpayer may determine the income from an exempt construction contract using any accounting method permitted by § 1.460–4(c) and, for contracts accounted for using the completed-contract method (CCM), any cost allocation method permitted by § 1.460–5(d). Exempt construction contracts that are not subject to the PCM or CCM are not subject to the cost allocation rules of § 1.460–5 except for the production-period interest rules of § 1.460–5(b)(2)(v). Exempt construction contractors that are large homebuilders described in § 1.460–5(d)(3) must capitalize costs under section 263A. All other exempt construction contractors must account for the cost of construction using the appropriate rules contained in other sections of the Internal Revenue Code or regulations.

(ii) *Qualified ship or residential construction contract.* The requirement to use the PCM applies only to a portion of a *qualified ship contract* described in § 1.460–2(d) or *residential construction contract* described in § 1.460–3(c). A taxpayer generally may determine the income from a qualified ship contract or residential construction contract using the percentage-of-completion/capitalized-cost method (PCCM) described in § 1.460–4(e), but must use a cost allocation method described in § 1.460–5(b) for the entire contract.

(b) *Terms*—(1) *Long-term contract. A long-term contract* generally is any contract for the manufacture, building, installation, or construction of property if the contract is not completed within the contracting year, as defined in paragraph (b)(5) of this section. However, a contract for the manufacture of property is a long-term contract only if it also satisfies either the unique item or 12-month requirements described in § 1.460–2. A contract for the manufacture of personal property is a *manufacturing contract.* In contrast, a contract for the building, installation, or construction of real property is a *construction contract.*

(2) *Contract for the manufacture, building, installation, or construction of property*—(i) *In general.* A contract is a *contract for the manufacture, building, installation, or construction of property* if the manufacture, building, installation, or construction of property is necessary for the taxpayer's contractual obligations to be fulfilled and if the manufacture, building, installation, or construction of that property has not been completed when the parties enter into the contract. If a taxpayer has to manufacture or construct an item to fulfill its obligations under the contract, the fact that the taxpayer is not required to deliver that item to the customer is not relevant. Whether the customer has title to, control over, or bears the risk of loss from, the property manufactured or constructed by the taxpayer also is not relevant. Furthermore, how the parties characterize their agreement (*e.g.,* as a contract for the sale of property) is not relevant.

(ii) *De minimis construction activities.* Notwithstanding paragraph (b)(2)(i) of this section, a contract is not a construction contract under section 460 if the contract includes the provision of land by the taxpayer and the estimated total allocable contract costs, as defined in paragraph (b)(3) of this section, attributable to the taxpayer's construction activities are less than 10 percent of the contract's total contract price, as defined in § 1.460–4(b)(4)(i). For the purposes of this paragraph (b)(2)(ii), the allocable contract costs attributable to the taxpayer's construction activities do not include the cost of the land provided to the customer. In addition, a contract's estimated total allocable contract costs include a proportionate share of the estimated cost of any common improvement that benefits the subject matter of the contract if the taxpayer is contractually obligated, or required by law, to construct the common improvement.

(3) *Allocable contract costs. Allocable contract costs* are costs that are allocable to a long-term contract under § 1.460–5.

(4) *Related party.* A *related party* is a person whose relationship to a taxpayer is described in section 707(b) or 267(b), determined without regard to section 267(f)(1)(A) and determined by replacing ''at least 80 percent'' with ''more than 50 percent'' for the purposes of determining the ownership of the stock of a corporation in sections 267(b)(2), (8), (10)(A), and (12).

(5) *Contracting year.* The *contracting year* is the taxable year in which a taxpayer enters into a contract as described in paragraph (c)(2) of this section.

(6) *Completion year.* The *completion year* is the taxable year in which a taxpayer completes a contract as described in paragraph (c)(3) of this section.

(7) *Contract commencement date.* The *contract commencement date* is the date that a taxpayer or related party first incurs any allocable contract costs, such as design and engineering costs, other than expenses attributable to bidding and negotiating activities. Generally, the contract commencement date is relevant in applying § 1.460–6(b)(3) (concerning the de minimis exception to the look-back method under section 460(b)(3)(B)); § 1.460–5(b)(2)(v)(B)(1)(*i*) (concerning the production period subject to interest allocation); § 1.460–2(d) (concerning qualified ship contracts); and § 1.460–3(b)(1)(ii) (concerning the construction period for exempt construction contracts).

(8) *Incurred. Incurred* has the meaning given in § 1.461–1(a)(2) (concerning the taxable year a liability is incurred under the accrual method of accounting), regardless of a taxpayer's overall method of accounting. See § 1.461–4(d)(2)(ii) for economic performance rules concerning the PCM.

(9) *Independent research and development expenses. Independent*

research and development expenses are any expenses incurred in the performance of research or development, except that this term does not include any expenses that are directly attributable to a particular long-term contract in existence when the expenses are incurred and this term does not include any expenses under an agreement to perform research or development.

(10) *Long-term contract methods of accounting. Long-term contract methods of accounting*, which include the PCM, the CCM, the PCCM, and the exempt-contract percentage-of-completion method (EPCM), are methods of accounting that may be used only for long-term contracts.

(c) *Entering into and completing long-term contracts*—(1) *In general.* To determine when a contract is entered into under paragraph (c)(2) of this section and completed under paragraph (c)(3) of this section, a taxpayer must consider all relevant allocable contract costs incurred and activities performed by itself, by related parties on its behalf, and by the customer, that are incident to or necessary for the long-term contract. In addition, to determine whether a contract is completed in the contracting year, the taxpayer may not consider when it expects to complete the contract.

(2) *Date contract entered into*—(i) *In general.* A taxpayer enters into a contract on the date that the contract binds both the taxpayer and the customer under applicable law, even if the contract is subject to unsatisfied conditions not within the taxpayer's control (such as obtaining financing). If a taxpayer delays entering into a contract for a principal purpose of avoiding section 460, however, the taxpayer will be treated as having entered into a contract not later than the contract commencement date.

(ii) *Options and change orders.* A taxpayer enters into a new contract on the date that the customer exercises an option or similar provision in a contract if that option or similar provision must be severed from the contract under paragraph (e) of this section. Similarly, a taxpayer enters into a new contract on the date that it accepts a change order or other similar agreement if the change order or other similar agreement must be severed from the contract under paragraph (e) of this section.

(3) *Date contract completed*—(i) *In general.* A taxpayer's contract is completed upon the earlier of—

(A) Use of the subject matter of the contract by the customer for its intended purpose (other than for testing) and at least 95 percent of the total allocable contract costs attributable to the subject matter have been incurred by the taxpayer; or

(B) Final completion and acceptance of the subject matter of the contract.

(ii) *Secondary items.* The date a contract accounted for using the CCM is completed is determined without regard to whether one or more secondary items have been used or finally completed and accepted. If any secondary items are incomplete at the end of the taxable year in which the primary subject matter of a contract is completed, the taxpayer must separate the portion of the gross contract price and the allocable contract costs attributable to the incomplete secondary item(s) from the completed contract and account for them using a permissible method of accounting. A permissible method of accounting includes a long-term contract method of accounting only if a separate contract for the secondary item(s) would be a long-term contract, as defined in paragraph (b)(1) of this section.

(iii) *Subcontracts.* In the case of a subcontract, a subcontractor's customer is the general contractor. Thus, the subject matter of the subcontract is the relevant subject matter under paragraph (c)(3)(i) of this section.

(iv) *Final completion and acceptance*—(A) *In general.* Except as otherwise provided in this paragraph (c)(3)(iv), to determine whether final completion and acceptance of the subject matter of a contract have occurred, a taxpayer must consider all relevant facts and circumstances. Nevertheless, a taxpayer may not delay the completion of a contract for the principal purpose of deferring federal income tax.

(B) *Contingent compensation.* Final completion and acceptance is determined without regard to any contractual term that provides for additional compensation that is contingent on the successful performance of the subject matter of the contract. A taxpayer must account for all contingent compensation that is not includible in total contract price under § 1.460–4(b)(4)(i), or in gross contract price under § 1.460–4(d)(3), using a permissible method of accounting. For application of the look-back method for contracts accounted for using the PCM, see § 1.460–6(c)(1)(ii) and (2)(vi).

(C) *Assembly or installation.* Final completion and acceptance is determined without regard to whether the taxpayer has an obligation to assist or supervise assembly or installation of the subject matter of the contract where the assembly or installation is not performed by the taxpayer or a related party. A taxpayer must account for the gross receipts and costs attributable to such an obligation using a permissible method of accounting, other than a long-term contract method.

(D) *Disputes.* Final completion and acceptance is determined without regard to whether a dispute exists at the time the taxpayer tenders the subject matter of the contract to the customer. For contracts accounted for using the CCM, see § 1.460–4(d)(4). For application of the look-back method for contracts accounted for using the PCM, see § 1.460–6(c)(1)(ii) and (2)(vi).

(d) *Allocation among activities*—(1) *In general.* Long-term contract methods of accounting apply only to the gross receipts and costs attributable to long-term contract activities. Gross receipts and costs attributable to long-term contract activities means amounts included in total contract price or gross contract price, whichever is applicable, as determined under § 1.460–4, and costs allocable to the contract, as determined under § 1.460–5. Gross receipts and costs attributable to non-long-term contract activities (as defined in paragraph (d)(2) of this section) generally must be taken into account using a permissible method of accounting other than a long-term contract method. See section 446(c) and § 1.446–1(c). However, if the performance of a non-long-term contract activity is incident to or necessary for the manufacture, building, installation, or construction of the subject matter of one or more of the taxpayer's long-term contracts, the gross receipts and costs attributable to that activity must be allocated to the long-term contract(s) benefitted as provided in §§ 1.460–4(b)(4)(i) and 1.460–5(f)(2), respectively. Similarly, if a single long-term contract requires a taxpayer to perform a non-long-term contract activity that is not incident to or necessary for the manufacture, building, installation, or construction of the subject matter of the long-term contract, the gross receipts and costs attributable to that non-long-term contract activity must be separated from the contract and accounted for using a permissible method of accounting other than a long-term contract method. But see paragraph (g) of this section for related party rules.

(2) *Non-long-term contract activity. Non-long-term contract activity* means the performance of an activity other than manufacturing, building, installation, or construction, such as the provision of architectural, design, engineering, and construction management services, and the development or implementation of computer software. In addition, performance under a guaranty,

warranty, or maintenance agreement is a non-long-term contract activity that is never incident to or necessary for the manufacture or construction of property under a long-term contract.

(e) *Severing and aggregating contracts*—(1) *In general.* After application of the allocation rules of paragraph (d) of this section, the severing and aggregating rules of this paragraph (e) may be applied by the Commissioner or the taxpayer as necessary to clearly reflect income (*e.g.*, to prevent the unreasonable deferral (or acceleration) of income or the premature recognition (or deferral) of loss). Under the severing and aggregating rules, one agreement may be treated as two or more contracts, and two or more agreements may be treated as one contract. Except as provided in paragraph (e)(3)(ii) of this section, a taxpayer must determine whether to sever an agreement or to aggregate two or more agreements based on the facts and circumstances known at the end of the contracting year.

(2) *Facts and circumstances.* Whether an agreement should be severed, or two or more agreements should be aggregated, depends on the following factors:

(i) *Pricing.* Independent pricing of items in an agreement is necessary for the agreement to be severed into two or more contracts. In the case of an agreement for similar items, if the price to be paid for the items is determined under different terms or formulas (e.g., if some items are priced under a cost-plus incentive fee arrangement and later items are to be priced under a fixed-price arrangement), then the difference in the pricing terms or formulas indicates that the items are independently priced. Similarly, interdependent pricing of items in separate agreements is necessary for two or more agreements to be aggregated into one contract. A single price negotiation for similar items ordered under one or more agreements indicates that the items are interdependently priced.

(ii) *Separate delivery or acceptance.* An agreement may not be severed into two or more contracts unless it provides for separate delivery or separate acceptance of items that are the subject matter of the agreement. However, the separate delivery or separate acceptance of items by itself does not necessarily require an agreement to be severed.

(iii) *Reasonable businessperson.* Two or more agreements to perform manufacturing or construction activities may not be aggregated into one contract unless a reasonable businessperson would not have entered into one of the agreements for the terms agreed upon without also entering into the other agreement(s). Similarly, an agreement to perform manufacturing or construction activities may not be severed into two or more contracts if a reasonable businessperson would not have entered into separate agreements containing terms allocable to each severed contract. Analyzing the reasonable businessperson standard requires an analysis of all the facts and circumstances of the business arrangement between the taxpayer and the customer. For purposes of this paragraph (e)(2)(iii), a taxpayer's expectation that the parties would enter into another agreement, when agreeing to the terms contained in the first agreement, is not relevant.

(3) *Exceptions*—(i) *Severance for PCM.* A taxpayer may not sever under this paragraph (e) a long-term contract that would be subject to the PCM without obtaining the Commissioner's prior written consent.

(ii) *Options and change orders.* Except as provided in paragraph (e)(3)(i) of this section, a taxpayer must sever an agreement that increases the number of units to be supplied to the customer, such as through the exercise of an option or the acceptance of a change order, if the agreement provides for separate delivery or separate acceptance of the additional units.

(4) *Statement with return.* If a taxpayer severs an agreement or aggregates two or more agreements under this paragraph (e) during the taxable year, the taxpayer must attach a statement to its original federal income tax return for that year. This statement must contain the following information—

(i) The legend NOTIFICATION OF SEVERANCE OR AGGREGATION UNDER SEC. 1.460–1(e);

(ii) The taxpayer's name; and

(iii) The taxpayer's employer identification number or social security number.

(f) *Classifying contracts*—(1) *In general.* After applying the severing and aggregating rules of paragraph (e) of this section, a taxpayer must determine the classification of a contract (*e.g.*, as a long-term manufacturing contract, long-term construction contract, non-long-term contract) based on all the facts and circumstances known no later than the end of the contracting year. Classification is determined on a contract-by-contract basis. Consequently, a requirement to manufacture a single unique item under a long-term contract will subject all other items in that contract to section 460.

(2) *Hybrid contracts*—(i) *In general.* A long-term contract that requires a taxpayer to perform both manufacturing and construction activities (hybrid contract) generally must be classified as two contracts, a manufacturing contract and a construction contract. A taxpayer may elect, on a contract-by-contract basis, to classify a hybrid contract as a long-term construction contract if at least 95 percent of the estimated total allocable contract costs are reasonably allocable to construction activities. In addition, a taxpayer may elect, on a contract-by-contract basis, to classify a hybrid contract as a long-term manufacturing contract subject to the PCM.

(ii) *Elections.* A taxpayer makes an election under this paragraph (f)(2) by using its method of accounting for similar construction contracts or for manufacturing contracts, whichever is applicable, to account for a hybrid contract entered into during the taxable year of the election on its original federal income tax return for the election year. If an electing taxpayer's method is the PCM, the taxpayer also must use the PCM to apply the look-back method under § 1.460–6 and to determine alternative minimum taxable income under § 1.460–4(f).

(3) *Method of accounting.* Except as provided in paragraph (f)(2)(ii) of this section, a taxpayer's method of classifying contracts is a method of accounting under section 446 and, thus, may not be changed without the Commissioner's consent. If a taxpayer's method of classifying contracts is unreasonable, that classification method is an impermissible accounting method.

(4) *Use of estimates*—(i) *Estimating length of contract.* A taxpayer must use a reasonable estimate of the time required to complete a contract when necessary to classify the contract (e.g., to determine whether the five-year completion rule for qualified ship contracts under § 1.460–2(d), or the two-year completion rule for exempt construction contracts under § 1.460–3(b), is satisfied, but not to determine whether a contract is completed within the contracting year under paragraph (b)(1) of this section). To be considered reasonable, an estimate of the time required to complete the contract must include anticipated time for delay, rework, change orders, technology or design problems, or other problems that reasonably can be anticipated considering the nature of the contract and prior experience. A contract term that specifies an expected completion or delivery date may be considered evidence that the taxpayer reasonably expects to complete or deliver the

subject matter of the contract on or about the date specified, especially if the contract provides bona fide penalties for failing to meet the specified date. If a taxpayer classifies a contract based on a reasonable estimate of completion time, the contract will not be reclassified based on the actual (or another reasonable estimate of) completion time. A taxpayer's estimate of completion time will not be considered unreasonable if a contract is not completed within the estimated time primarily because of unforeseeable factors not within the taxpayer's control, such as third-party litigation, extreme weather conditions, strikes, or delays in securing permits or licenses.

(ii) *Estimating allocable contract costs.* A taxpayer must use a reasonable estimate of total allocable contract costs when necessary to classify the contract (e.g., to determine whether a contract is a home construction contract under § 1.460–(3)(b)(2)). If a taxpayer classifies a contract based on a reasonable estimate of total allocable contract costs, the contract will not be reclassified based on the actual (or another reasonable estimate of) total allocable contract costs.

(g) *Special rules for activities benefitting long-term contracts of a related party*—(1) *Related party use of PCM*—(i) *In general.* Except as provided in paragraph (g)(1)(ii) of this section, if a related party and its customer enter into a long-term contract subject to the PCM, and a taxpayer performs any activity that is incident to or necessary for the related party's long-term contract, the taxpayer must account for the gross receipts and costs attributable to this activity using the PCM, even if this activity is not otherwise subject to section 460(a). This type of activity may include, for example, the performance of engineering and design services, and the production of components and subassemblies that are reasonably expected to be used in the production of the subject matter of the related party's contract.

(ii) *Exception for components and subassemblies.* A taxpayer is not required to use the PCM under this paragraph (g) to account for a component or subassembly that benefits a related party's long-term contract if more than 50 percent of the average annual gross receipts attributable to the sale of this item for the 3-taxable-year-period ending with the contracting year comes from unrelated parties.

(2) *Total contract price.* If a taxpayer is required to use the PCM under paragraph (g)(1)(i) of this section, the total contract price (as defined in § 1.460–4(b)(4)(i)) is the fair market value of the taxpayer's activity that is incident to or necessary for the performance of the related party's long-term contract. The related party also must use the fair market value of the taxpayer's activity as the cost it incurs for the activity. The fair market value of the taxpayer's activity may or may not be the same as the amount the related party pays the taxpayer for that activity.

(3) *Completion factor.* To compute a contract's completion factor (as described in § 1.460–4(b)(5)), the related party must take into account the fair market value of the taxpayer's activity that is incident to or necessary for the performance of the related party's long-term contract when the related party incurs the liability to the taxpayer for the activity, rather than when the taxpayer incurs the costs to perform the activity.

(h) *Effective date*—(1) *In general.* Except as otherwise provided, this section and §§ 1.460–2 through 1.460–5 are applicable for contracts entered into on or after January 11, 2001.

(2) *Change in method of accounting.* Any change in a taxpayer's method of accounting necessary to comply with this section and §§ 1.460–2 through 1.460–5 is a change in method of accounting to which the provisions of section 446 and the regulations thereunder apply. For the first taxable year that includes January 11, 2001, a taxpayer is granted the consent of the Commissioner to change its method of accounting to comply with the provisions of this section and §§ 1.460–2 through 1.460–5 for long-term contracts entered into on or after January 11, 2001. A taxpayer that wants to change its method of accounting under this paragraph (h)(2) must follow the automatic consent procedures in Rev. Proc. 99–49 (1999–52 I.R.B. 725) (see § 601.601(d)(2) of this chapter), except that the scope limitations in section 4.02 of Rev. Proc. 99–49 do not apply. Because a change under this paragraph (h)(2) is made on a cut-off basis, a section 481(a) adjustment is not permitted or required. Moreover, the taxpayer does not receive audit protection under section 7 of Rev. Proc. 99–49 for a change in method of accounting under this paragraph (h)(2). A taxpayer that wants to change its exempt-contract method of accounting is not granted the consent of the Commissioner under this paragraph (h)(2) and must file a Form 3115, ''Application for Change in Accounting Method,'' to obtain consent. See Rev. Proc. 97–27 (1997–1 C.B. 680) (see § 601.601(d)(2) of this chapter).

(i) [Reserved]

(j) *Examples.* The following examples illustrate the rules of this section:

Example 1. Contract for manufacture of property. B notifies C, an aircraft manufacturer, that it wants to purchase an aircraft of a particular type. At the time C receives the order, C has on hand several partially completed aircraft of this type; however, C does not have any completed aircraft of this type on hand. C and B agree that B will purchase one of these aircraft after it has been completed. C retains title to and risk of loss with respect to the aircraft until the sale takes place. The agreement between C and B is a contract for the manufacture of property under paragraph (b)(2)(i) of this section, even if labeled as a contract for the sale of property, because the manufacture of the aircraft is necessary for C's obligations under the agreement to be fulfilled and the manufacturing was not complete when B and C entered into the agreement.

Example 2. De minimis construction activity. C, a master developer whose taxable year ends December 31, owns 5,000 acres of undeveloped land with a cost basis of $5,000,000 and a fair market value of $50,000,000. To obtain permission from the local county government to improve this land, a service road must be constructed on this land to benefit all 5,000 acres. In 2001, C enters into a contract to sell a 1,000-acre parcel of undeveloped land to B, a residential developer, for its fair market value, $10,000,000. In this contract, C agrees to construct a service road running through the land that C is selling to B and through the 4,000 adjacent acres of undeveloped land that C has sold or will sell to other residential developers for its fair market value, $40,000,000. C reasonably estimates that it will incur allocable contract costs of $50,000 (excluding the cost of the land) to construct this service road, which will be owned and maintained by the county. C must reasonably allocate the cost of the service road among the benefitted parcels. The portion of the estimated total allocable contract costs that C allocates to the 1,000-acre parcel being sold to B (based upon its fair market value) is $10,000 ($50,000 x ($10,000,000 $50,000,000)). Construction of the service road is finished in 2002. Because the estimated total allocable contract costs attributable to C's construction activities, $10,000, are less than 10 percent of the contract's total contract price, $10,000,000, C's contract with B is not a construction contract under paragraph (b)(2)(ii) of this section. Thus, C's contract with B is not a long-term contract under paragraph (b)(2)(i) of this section, notwithstanding that construction of the service road is not completed in 2001.

Example 3. Completion—customer use. In 2002, C, whose taxable year ends December 31, enters into a contract to construct a building for B. In November of 2003, the building is completed in every respect necessary for its intended use, and B occupies the building. In early December of 2003, B notifies C of some minor deficiencies that need to be corrected, and C agrees to correct them in January 2004. C reasonably estimates that the cost of correcting these deficiencies will be less than five percent of

the total allocable contract costs. C's contract is complete under paragraph (c)(3)(i)(A) of this section in 2003 because in that year, B used the building and C had incurred at least 95 percent of the total allocable contract costs attributable to the building. C must use a permissible method of accounting for any deficiency-related costs incurred after 2003.

Example 4. Completion—customer use. In 2001, C, whose taxable year ends December 31, agrees to construct a shopping center, which includes an adjoining parking lot, for B. By October 2002, C has finished constructing the retail portion of the shopping center. By December 2002, C has graded the entire parking lot, but has paved only one-fourth of it because inclement weather conditions prevented C from laying asphalt on the remaining three-fourths. In December 2002, B opens the retail portion of the shopping center and the paved portion of the parking lot to the general public. C reasonably estimates that the cost of paving the remaining three-fourths of the parking lot when weather permits will exceed five percent of C's total allocable contract costs. Even though B is using the subject matter of the contract, C's contract is not completed in December 2002 under paragraph (c)(3)(i)(A) of this section because C has not incurred at least 95 percent of the total allocable contract costs attributable to the subject matter.

Example 5. Completion—customer use. In 2001, C, whose taxable year ends December 31, agrees to manufacture 100 machines for B. By December 31, 2002, C has delivered 99 of the machines to B. C reasonably estimates that the cost of finishing the related work on the contract will be less than five percent of the total allocable contract costs. C's contract is not complete under paragraph (c)(3)(i)(A) of this section in 2002 because in that year, B is not using the subject matter of the contract (all 100 machines) for its intended purpose.

Example 6. Non-long-term contract activity. On January 1, 2001, C, whose taxable year ends December 31, enters into a single long-term contract to design and manufacture a satellite and to develop computer software enabling B to operate the satellite. At the end of 2001, C has not finished manufacturing the satellite. Designing the satellite and developing the computer software are non-long-term contract activities that are incident to and necessary for the taxpayer's manufacturing of the subject matter of a long-term contract because the satellite could not be manufactured without the design and would not operate without the software. Thus, under paragraph (d)(1) of this section, C must allocate these non-long-term contract activities to the long-term contract and account for the gross receipts and costs attributable to designing the satellite and developing computer software using the PCM.

Example 7. Non-long-term contract activity. C agrees to manufacture equipment for B under a long-term contract. In a separate contract, C agrees to design the equipment being manufactured for B under the long-term contract. Under paragraph (d)(1) of this section, C must allocate the gross receipts and costs related to the design to the long-term contract because designing the equipment is a non-long-term contract activity that is incident to and necessary for the manufacture of the subject matter of the long-term contract.

Example 8. Severance. On January 1, 2001, C, a construction contractor, and B, a real estate investor, enter into an agreement requiring C to build two office buildings in different areas of a large city. The agreement provides that the two office buildings will be completed by C and accepted by B in 2002 and 2003, respectively, and that C will be paid $1,000,000 and $1,500,000 for the two office buildings, respectively. The agreement will provide C with a reasonable profit from the construction of each building. Unless C is required to use the PCM to account for the contract, C is required to sever this contract under paragraph (e)(2) of this section because the buildings are independently priced, the agreement provides for separate delivery and acceptance of the buildings, and, as each building will generate a reasonable profit, a reasonable businessperson would have entered into separate agreements for the terms agreed upon for each building.

Example 9. Severance. C, a large construction contractor whose taxable year ends December 31, accounts for its construction contracts using the PCM and has elected to use the 10-percent method described in § 1.460–4(b)(6). In September 2001, C enters into an agreement to construct four buildings in four different cities. The buildings are independently priced and the contract provides a reasonable profit for each of the buildings. In addition, the agreement requires C to complete one building per year in 2002, 2003, 2004, and 2005. As of December 31, 2001, C has incurred 25 percent of the estimated total allocable contract costs attributable to one of the buildings, but only five percent of the estimated total allocable contract costs attributable to all four buildings included in the agreement. C does not request the Commissioner's consent to sever this contract. Using the 10-percent method, C does not take into account any portion of the total contract price or any incurred allocable contract costs attributable to this agreement in 2001. Upon examination of C's 2001 tax return, the Commissioner determines that C entered into one agreement for four buildings rather than four separate agreements each for one building solely to take advantage of the deferral obtained under the 10-percent method. Consequently, to clearly reflect the taxpayer's income, the Commissioner may require C to sever the agreement into four separate contracts under paragraph (e)(2) of this section because the buildings are independently priced, the agreement provides for separate delivery and acceptance of the buildings, and a reasonable businessperson would have entered into separate agreements for these buildings.

Example 10. Aggregation. In 2001, C, a shipbuilder, enters into two agreements with the Department of the Navy as the result of a single negotiation. Each agreement obligates C to manufacture a submarine. Because the submarines are of the same class, their specifications are similar. Because C has never manufactured submarines of this class, however, C anticipates that it will incur substantially higher costs to manufacture the first submarine, to be delivered in 2007, than to manufacture the second submarine, to be delivered in 2010. If the agreements are treated as separate contracts, the first contract probably will produce a substantial loss, while the second contract probably will produce substantial profit. Based upon these facts, aggregation is required under paragraph (e)(2) of this section because the submarines are interdependently priced and a reasonable businessperson would not have entered the first agreement without also entering into the second.

Example 11. Aggregation. In 2001, C, a manufacturer of aircraft and related equipment, agrees to manufacture 10 military aircraft for foreign government B and to deliver the aircraft by the end of 2003. When entering into the agreement, C anticipates that it might receive production orders from B over the next 20 years for as many as 300 more of these aircraft. The negotiated contract price reflects C's and B's consideration of the expected total cost of manufacturing the 10 aircraft, the risks and opportunities associated with the agreement, and the additional factors the parties considered relevant. The negotiated price provides a profit on the sale of the 10 aircraft even if C does not receive any additional production orders from B. It is unlikely, however, that C actually would have wanted to manufacture the 10 aircraft but for the expectation that it would receive additional production orders from B. In 2003, B accepts delivery of the 10 aircraft. At that time, B orders an additional 20 aircraft of the same type for delivery in 2007. When negotiating the price for the additional 20 aircraft, C and B consider the fact that the expected unit cost for this production run of 20 aircraft will be lower than the unit cost of the 10 aircraft completed and accepted in 2003, but substantially higher than the expected unit cost of future production runs. Based upon these facts, aggregation is not permitted under paragraph (e)(2) of this section. Because the parties negotiated the prices of both agreements considering only the expected production costs and risks for each agreement standing alone, the terms and conditions agreed upon for the first agreement are independent of the terms and conditions agreed upon for the second agreement. The fact that the agreement to manufacture 10 aircraft provides a profit for C indicates that a reasonable businessperson would have entered into that agreement without entering into the agreement to manufacture the additional 20 aircraft.

Example 12. Classification and completion. In 2001, C, whose taxable year ends December 31, agrees to manufacture and install an industrial machine for B. C elects under paragraph (f) of this section to classify the agreement as a long-term manufacturing contract and to account for it using the PCM. The agreement requires C to deliver the machine in August 2003 and to install and test the machine in B's factory. In addition, the agreement requires B to accept the machine when the tests prove that the machine's performance will satisfy the environmental standards set by the Environmental Protection Agency (EPA),

even if B has not obtained the required operating permit. Because of technical difficulties, C cannot deliver the machine until December 2003, when B conditionally accepts delivery. C installs the machine in December 2003 and then tests it through February 2004. B accepts the machine in February 2004, but does not obtain the operating permit from the EPA until January 2005. Under paragraph (c)(3)(i)(B) of this section, C's contract is finally completed and accepted in February 2004, even though B does not obtain the operating permit until January 2005, because C completed all its obligations under the contract and B accepted the machine in February 2004.

§ 1.460–2 Long-term manufacturing contracts.

(a) *In general.* Section 460 generally requires a taxpayer to determine the income from a long-term manufacturing contract using the percentage-of-completion method described in § 1.460–4(b) (PCM). A contract not completed in the contracting year is a long-term manufacturing contract if it involves the manufacture of personal property that is—

(1) A unique item of a type that is not normally carried in the finished goods inventory of the taxpayer; or

(2) An item that normally requires more than 12 calendar months to complete (regardless of the duration of the contract or the time to complete a deliverable quantity of the item).

(b) *Unique*—(1) *In general. Unique* means designed for the needs of a specific customer. To determine whether an item is designed for the needs of a specific customer, a taxpayer must consider the extent to which research, development, design, engineering, retooling, and similar activities (customizing activities) are required to manufacture the item and whether the item could be sold to other customers with little or no modification. A contract may require the taxpayer to manufacture more than one unit of a unique item. If a contract requires a taxpayer to manufacture more than one unit of the same item, the taxpayer must determine whether that item is unique by considering the customizing activities that would be needed to produce only the first unit. For the purposes of this paragraph (b), a taxpayer must consider the activities performed on its behalf by a subcontractor.

(2) *Safe harbors.* Notwithstanding paragraph (b)(1) of this section, an item is not unique if it satisfies one or more of the safe harbors in this paragraph (b)(2). If an item does not satisfy one or more safe harbors, the determination of uniqueness will depend on the facts and circumstances. The safe harbors are:

(i) *Short production period.* An item is not unique if it normally requires 90 days or less to complete. In the case of a contract for multiple units of an item, the item is not unique only if it normally requires 90 days or less to complete each unit of the item in the contract.

(ii) *Customized item.* An item is not unique if the total allocable contract costs attributable to customizing activities that are incident to or necessary for the manufacture of the item do not exceed 10 percent of the estimated total allocable contract costs allocable to the item. In the case of a contract for multiple units of an item, this comparison must be performed on the first unit of the item and the total allocable contract costs attributable to customizing activities that are incident to or necessary for the manufacture of the item must be allocated to the first unit.

(iii) *Inventoried item.* A unique item ceases to be unique no later than when the taxpayer normally includes similar items in its finished goods inventory.

(c) *Normal time to complete*—(1) *In general.* The amount of time normally required to complete an item is the item's reasonably expected *production period,* as described in § 1.263A–12, determined at the end of the contracting year. Thus, in general, the expected production period for an item begins when a taxpayer incurs at least five percent of the costs that would be allocable to the item under § 1.460–5 and ends when the item is ready to be held for sale and all reasonably expected production activities are complete. In the case of components that are assembled or reassembled into an item or unit at the customer's facility by the taxpayer's employees or agents, the production period ends when the components are assembled or reassembled into an operable item or unit. To the extent that several distinct activities related to the production of the item are expected to occur simultaneously, the period during which these distinct activities occur is not counted more than once. Furthermore, when determining the normal time to complete an item, a taxpayer is not required to consider activities performed or costs incurred that would not be allocable contract costs under section 460 (*e.g.,* independent research and development expenses (as defined in § 1.460–1(b)(9)) and marketing expenses). Moreover, the time required to design and manufacture the first unit of an item for which the taxpayer intends to produce multiple units generally does not indicate the normal time to complete the item.

(2) *Production by related parties.* To determine the time normally required to complete an item, a taxpayer must consider all relevant production activities performed and costs incurred by itself and by related parties, as defined in § 1.460–1(b)(4). For example, if a taxpayer's item requires a component or subassembly manufactured by a related party, the taxpayer must consider the time the related party takes to complete the component or subassembly and, for purposes of determining the beginning of an item's production period, the costs incurred by the related party that are allocable to the component or subassembly. However, if both requirements of the exception for components and subassemblies under § 1.460–1(g)(1)(ii) are satisfied, a taxpayer does not consider the activities performed or the costs incurred by a related party when determining the normal time to complete an item.

(d) *Qualified ship contracts.* A taxpayer may determine the income from a long-term manufacturing contract that is a qualified ship contract using either the PCM or the percentage-of-completion/capitalized-cost method (PCCM) of accounting described in § 1.460–4(e). A *qualified ship contract* is any contract entered into after February 28, 1986, to manufacture in the United States not more than 5 seagoing vessels if the vessels will not be manufactured directly or indirectly for the United States Government and if the taxpayer reasonably expects to complete the contract within 5 years of the contract commencement date. Under § 1.460–1(e)(3)(i), a contract to produce more than 5 vessels for which the PCM would be required cannot be severed in order to be classified as a qualified ship contract.

(e) *Examples.* The following examples illustrate the rules of this section:

Example 1. Unique item and classification. In December 2001, C enters into a contract with B to design and manufacture a new type of industrial equipment. C reasonably expects the normal production period for this type of equipment to be eight months. Because the new type of industrial equipment requires a substantial amount of research, design, and engineering to produce, C determines that the equipment is a unique item and its contract with B is a long-term contract. After delivering the equipment to B in September 2002, C contracts with B to produce five additional units of that industrial equipment with certain different specifications. These additional units, which also are expected to take eight months to produce, will be delivered to B in 2003. C determines that the research, design,

engineering, retooling, and similar customizing costs necessary to produce the five additional units of equipment does not exceed 10 percent of the first unit's share of estimated total allocable contract costs. Consequently, the additional units of equipment satisfy the safe harbor in paragraph (b)(2)(ii) of this section and are not unique items. Although C's contract with B to produce the five additional units is not completed within the contracting year, the contract is not a long-term contract since the additional units of equipment are not unique items and do not normally require more than 12 months to produce. C must classify its second contract with B as a non-long term contract, notwithstanding that it classified the previous contract with B for a similar item as a long-term contract, because the determination of whether a contract is a long-term contract is made on a contract-by-contract basis. A change in classification is not a change in method of accounting because the change in classification results from a change in underlying facts.

Example 2. 12-month rule—related party. C manufactures cranes. C purchases one of the crane's components from R, a related party under § 1.460–1(b)(4). Less than 50 percent of R's gross receipts attributable to the sale of this component comes from sales to unrelated parties; thus, the exception for components and subassemblies under § 1.460–1(g)(1)(ii) is not satisfied. Consequently, C must consider the activities of R as R incurs costs and performs the activities rather than as C incurs a liability to R. The normal time period between the time that both C and R incur five percent of the costs allocable to the crane and the time that R completes the component is five months. C normally requires an additional eight months to complete production of the crane after receiving the integral component from R. C's crane is an item of a type that normally requires more than 12 months to complete under paragraph (c) of this section because the production period from the time that both C and R incur five percent of the costs allocable to the crane until the time that production of the crane is complete is normally 13 months.

Example 3. 12-month rule—duration of contract. The facts are the same as in *Example 2,* except that C enters into a sales contract with B on December 31, 2001 (the last day of C's taxable year), and delivers a completed crane to B on February 1, 2002. C's contract with B is a long-term contract under paragraph (a)(2) of this section because the contract is not completed in the contracting year, 2001, and the crane is an item that normally requires more than 12 calendar months to complete (regardless of the duration of the contract).

Example 4. 12-month rule—normal time to complete. The facts are the same as in *Example 2,* except that C (and R) actually complete B's crane in only 10 calendar months. The contract is a long-term contract because the normal time to complete a crane, not the actual time to complete a crane, is the relevant criterion for determining whether an item is subject to paragraph (a)(2) of this section.

Example 5. Normal time to complete. C enters into a multi-unit contract to produce four units of an item. C does not anticipate producing any additional units of the item. C expects to perform the research, design, and development that are directly allocable to the particular item and to produce the first unit in the first 24 months. C reasonably expects the production period for each of the three remaining units will be 3 months. This contract is not a contract that involves the manufacture of an item that normally requires more than 12 months to complete because the normal time to complete the item is 3 months. However, the contract does not satisfy the 90-day safe harbor for unique items because the normal time to complete the first unit of this item exceeds 90 days. Thus, the contract might involve the manufacture of a unique item depending on the facts and circumstances.

§ 1.460–3 Long-term construction contracts.

(a) *In general.* Section 460 generally requires a taxpayer to determine the income from a long-term construction contract using the percentage-of-completion method described in § 1.460–4(b) (PCM). A contract not completed in the contracting year is a long-term construction contract if it involves the building, construction, reconstruction, or rehabilitation of real property; the installation of an integral component to real property; or the improvement of real property (collectively referred to as construction). *Real property* means land, buildings, and *inherently permanent structures*, as defined in § 1.263A–8(c)(3), such as roadways, dams, and bridges. Real property does not include vessels, offshore drilling platforms, or unsevered natural products of land. An *integral component to real property* includes property not produced at the site of the real property but intended to be permanently affixed to the real property, such as elevators and central heating and cooling systems. Thus, for example, a contract to install an elevator in a building is a construction contract because a building is real property, but a contract to install an elevator in a ship is not a construction contract because a ship is not real property.

(b) *Exempt construction contracts*—(1) *In general.* The general requirement to use the PCM and the cost allocation rules described in § 1.460–5(b) or (c) does not apply to any long-term construction contract described in this paragraph (b) (exempt construction contract). *Exempt construction contract* means any—

(i) Home construction contract; and

(ii) Other construction contract that a taxpayer estimates (when entering into the contract) will be completed within 2 years of the contract commencement date, provided the taxpayer satisfies the $10,000,000 gross receipts test described in paragraph (b)(3) of this section.

(2) *Home construction contract*—(i) *In general.* A long-term construction contract is a *home construction contract* if a taxpayer (including a subcontractor working for a general contractor) reasonably expects to attribute 80 percent or more of the estimated total allocable contract costs (including the cost of land, materials, and services), determined as of the close of the contracting year, to the construction of—

(A) Dwelling units, as defined in section 168(e)(2)(A)(ii)(I), contained in buildings containing 4 or fewer dwelling units (including buildings with 4 or fewer dwelling units that also have commercial units); and

(B) Improvements to real property directly related to, and located at the site of, the dwelling units.

(ii) *Townhouses and rowhouses.* Each townhouse or rowhouse is a separate building.

(iii) *Common improvements.* A taxpayer includes in the cost of the dwelling units their allocable share of the cost that the taxpayer reasonably expects to incur for any common improvements (e.g., sewers, roads, clubhouses) that benefit the dwelling units and that the taxpayer is contractually obligated, or required by law, to construct within the tract or tracts of land that contain the dwelling units.

(iv) *Mixed use costs.* If a contract involves the construction of both commercial units and dwelling units within the same building, a taxpayer must allocate the costs among the commercial units and dwelling units using a reasonable method or combination of reasonable methods, such as specific identification, square footage, or fair market value.

(3) *$10,000,000 gross receipts test*—(i) *In general.* Except as otherwise provided in paragraphs (b)(3)(ii) and (iii) of this section, the $10,000,000 gross receipts test is satisfied if a taxpayer's (or predecessor's) average annual gross receipts for the 3 taxable years preceding the contracting year do not exceed $10,000,000, as determined using the principles of the gross receipts test for small resellers under § 1.263A–3(b).

(ii) *Single employer.* To apply the gross receipts test, a taxpayer is not required to aggregate the gross receipts of persons treated as a single employer solely under section 414(m) and any regulations prescribed under section 414.

(iii) *Attribution of gross receipts.* A taxpayer must aggregate a proportionate

share of the construction-related gross receipts of any person that has a five percent or greater interest in the taxpayer. In addition, a taxpayer must aggregate a proportionate share of the construction-related gross receipts of any person in which the taxpayer has a five percent or greater interest. For this purpose, a taxpayer must determine ownership interests as of the first day of the taxpayer's contracting year and must include indirect interests in any corporation, partnership, estate, trust, or sole proprietorship according to principles similar to the constructive ownership rules under sections 1563(e), (f)(2), and (f)(3)(A). However, a taxpayer is not required to aggregate under this paragraph (b)(3)(iii) any construction-related gross receipts required to be aggregated under paragraph (b)(3)(i) of this section.

(c) *Residential construction contracts.* A taxpayer may determine the income from a long-term construction contract that is a residential construction contract using either the PCM or the percentage-of-completion/capitalized-cost method (PCCM) of accounting described in § 1.460–4(e). A *residential construction contract* is a home construction contract, as defined in paragraph (b)(2) of this section, except that the building or buildings being constructed contain more than 4 dwelling units.

Par. 7. Section 1.460–4 is amended by adding paragraphs (a) through (i) to read as follows:

§ 1.460–4 Methods of accounting for long-term contracts.

(a) *Overview.* This section prescribes permissible methods of accounting for long-term contracts. Paragraph (b) of this section describes the percentage-of-completion method under section 460(b) (PCM) that a taxpayer generally must use to determine the income from a long-term contract. Paragraph (c) of this section lists permissible methods of accounting for exempt construction contracts described in § 1.460–3(b)(1) and describes the exempt-contract percentage-of-completion method (EPCM). Paragraph (d) of this section describes the completed-contract method (CCM), which is one of the permissible methods of accounting for exempt construction contracts. Paragraph (e) of this section describes the percentage-of-completion/capitalized-cost method (PCCM), which is a permissible method of accounting for qualified ship contracts described in § 1.460–2(d) and residential construction contracts described in § 1.460–3(c). Paragraph (f) of this section provides rules for determining the alternative minimum taxable income (AMTI) from long-term contracts that are not exempted under section 56. Paragraph (g) of this section provides rules concerning consistency in methods of accounting for long-term contracts. Paragraph (h) of this section provides examples illustrating the principles of this section. Paragraph (j) of this section provides rules for taxpayers that file consolidated tax returns.

(b) *Percentage-of-completion method*—(1) *In general.* Under the PCM, a taxpayer generally must include in income the portion of the *total contract price,* as defined in paragraph (b)(4)(i) of this section, that corresponds to the percentage of the entire contract that the taxpayer has completed during the taxable year. The percentage of completion must be determined by comparing allocable contract costs incurred with estimated total allocable contract costs. Thus, the taxpayer includes a portion of the total contract price in gross income as the taxpayer incurs allocable contract costs.

(2) *Computations.* To determine the income from a long-term contract, a taxpayer—

(i) Computes the *completion factor* for the contract, which is the ratio of the cumulative allocable contract costs that the taxpayer has incurred through the end of the taxable year to the estimated total allocable contract costs that the taxpayer reasonably expects to incur under the contract;

(ii) Computes the amount of *cumulative gross receipts* from the contract by multiplying the completion factor by the total contract price;

(iii) Computes the amount of *current-year gross receipts,* which is the difference between the amount of cumulative gross receipts for the current taxable year and the amount of cumulative gross receipts for the immediately preceding taxable year (the difference can be a positive or negative number); and

(iv) Takes both the current-year gross receipts and the allocable contract costs incurred during the current year into account in computing taxable income.

(3) *Post-completion-year income.* If a taxpayer has not included the total contract price in gross income by the completion year, as defined in § 1.460–1(b)(6), the taxpayer must include the remaining portion of the total contract price in gross income for the taxable year following the completion year. For the treatment of post-completion costs, see paragraph (b)(5)(v) of this section. See § 1.460–6(c)(1)(ii) for application of the look-back method as a result of adjustments to total contract price.

(4) *Total contract price*—(i) *In general*—(A) *Definition. Total contract price* means the amount that a taxpayer reasonably expects to receive under a long-term contract, including holdbacks, retainages, and cost reimbursements. See § 1.460–6(c)(1)(ii) and (2)(vi) for application of the look-back method as a result of changes in total contract price.

(B) *Contingent compensation.* Any amount related to a contingent right under a contract, such as a bonus, award, incentive payment, and amount in dispute, is included in total contract price as soon as the taxpayer can reasonably predict that the amount will be earned, even if the all events test has not yet been met. For example, if a bonus is payable to a taxpayer for meeting an early completion date, the bonus is includible in total contract price at the time and to the extent that the taxpayer can reasonably predict the achievement of the corresponding objective. Similarly, a portion of the contract price that is in dispute is includible in total contract price at the time and to the extent that the taxpayer can reasonably predict that the dispute will be resolved in the taxpayer's favor (regardless of when the taxpayer actually receives payment or when the dispute is finally resolved). Total contract price does not include compensation that might be earned under any other agreement that the taxpayer expects to obtain from the same customer (*e.g.*, exercised option or follow-on contract) if that other agreement is not aggregated under § 1.460–1(e). For the purposes of this paragraph (b)(4)(i)(B), a taxpayer can reasonably predict that an amount of contingent income will be earned not later than when the taxpayer includes that amount in income for financial reporting purposes under generally accepted accounting principles. If a taxpayer has not included an amount of contingent compensation in total contract price under this paragraph (b)(4)(i) by the taxable year following the completion year, the taxpayer must account for that amount of contingent compensation using a permissible method of accounting. If it is determined after the taxable year following the completion year that an amount included in total contract price will not be earned, the taxpayer should deduct that amount in the year of the determination.

(C) *Non-long-term contract activities.* Total contract price includes an allocable share of the gross receipts attributable to a non-long-term contract activity, as defined in § 1.460–1(d)(2), if the activity is incident to or necessary

for the manufacture, building, installation, or construction of the subject matter of the long-term contract. Total contract price also includes amounts reimbursed for independent research and development expenses (as defined in § 1.460–1(b)(9)), or for bidding and proposal costs, under a federal or cost-plus long-term contract (as defined in section 460(d)), regardless of whether the research and development, or bidding and proposal, activities are incident to or necessary for the performance of that long-term contract.

(ii) *Estimating total contract price.* A taxpayer must estimate the total contract price based upon all the facts and circumstances known as of the last day of the taxable year. For this purpose, an event that occurs after the end of the taxable year must be taken into account if its occurrence was reasonably predictable and its income was subject to reasonable estimation as of the last day of that taxable year.

(5) *Completion factor*—(i) *Allocable contract costs.* A taxpayer must use a cost allocation method permitted under either § 1.460–5(b) or (c) to determine the amount of cumulative allocable contract costs and estimated total allocable contract costs that are used to determine a contract's completion factor. Allocable contract costs include a reimbursable cost that is allocable to the contract.

(ii) *Cumulative allocable contract costs.* To determine a contract's completion factor for a taxable year, a taxpayer must take into account the cumulative allocable contract costs that have been incurred, as defined in § 1.460–1(b)(8), through the end of the taxable year.

(iii) *Estimating total allocable contract costs.* A taxpayer must estimate total allocable contract costs for each long-term contract based upon all the facts and circumstances known as of the last day of the taxable year. For this purpose, an event that occurs after the end of the taxable year must be taken into account if its occurrence was reasonably predictable and its cost was subject to reasonable estimation as of the last day of that taxable year. To be considered reasonable, an estimate of total allocable contract costs must include costs attributable to delay, rework, change orders, technology or design problems, or other problems that reasonably can be predicted considering the nature of the contract and prior experience. However, estimated total allocable contract costs do not include any contingency allowance for costs that, as of the end of the taxable year, are not reasonably predicted to be incurred in the performance of the contract. For example, estimated total allocable contract costs do not include any costs attributable to factors not reasonably predictable at the end of the taxable year, such as third-party litigation, extreme weather conditions, strikes, and delays in securing required permits and licenses. In addition, the estimated costs of performing other agreements that are not aggregated with the contract under § 1.460–1(e) that the taxpayer expects to incur with the same customer (*e.g.*, follow-on contracts) are not included in estimated total allocable contract costs for the initial contract.

(iv) *Pre-contracting-year costs.* If a taxpayer reasonably expects to enter into a long-term contract in a future taxable year, the taxpayer must capitalize all costs incurred prior to entering into the contract that will be allocable to that contract (*e.g.*, bidding and proposal costs). A taxpayer is not required to compute a completion factor, or to include in gross income any amount, related to allocable contract costs for any taxable year ending before the contracting year or, if applicable, the 10-percent year defined in paragraph (b)(6)(i) of this section. In that year, the taxpayer is required to compute a completion factor that includes all allocable contract costs that have been incurred as of the end of that taxable year (whether previously capitalized or deducted) and to take into account in computing taxable income the related gross receipts and the previously capitalized allocable contract costs. If, however, a taxpayer determines in a subsequent year that it will not enter into the long-term contract, the taxpayer must account for these pre-contracting-year costs in that year (*e.g.*, as a deduction or an inventoriable cost) using the appropriate rules contained in other sections of the Code or regulations.

(v) *Post-completion-year costs.* If a taxpayer incurs an allocable contract cost after the completion year, the taxpayer must account for that cost using a permissible method of accounting. See § 1.460–6(c)(1)(ii) for application of the look-back method as a result of adjustments to allocable contract costs.

(6) *10-percent method*—(i) *In general.* Instead of determining the income from a long-term contract beginning with the contracting year, a taxpayer may elect to use the 10-percent method under section 460(b)(5). Under the 10-percent method, a taxpayer does not include in gross income any amount related to allocable contract costs until the taxable year in which the taxpayer has incurred at least 10 percent of the estimated total allocable contract costs (10-percent year). A taxpayer must treat costs incurred before the 10-percent year as pre-contracting-year costs described in paragraph (b)(5)(iv) of this section.

(ii) *Election.* A taxpayer makes an election under this paragraph (b)(6) by using the 10-percent method for all long-term contracts entered into during the taxable year of the election on its original federal income tax return for the election year. This election is a method of accounting and, thus, applies to all long-term contracts entered into during and after the taxable year of the election. An electing taxpayer must use the 10-percent method to apply the look-back method under § 1.460–6 and to determine alternative minimum taxable income under paragraph (f) of this section. This election is not available if a taxpayer uses the simplified cost-to-cost method described in § 1.460-5(c) to compute the completion factor of a long-term contract.

(7) *Terminated contract*—(i) *Reversal of income.* If a long-term contract is terminated before completion and, as a result, the taxpayer retains ownership of the property that is the subject matter of that contract, the taxpayer must reverse the transaction in the taxable year of termination. To reverse the transaction, the taxpayer reports a loss (or gain) equal to the cumulative allocable contract costs reported under the contract in all prior taxable years less the cumulative gross receipts reported under the contract in all prior taxable years.

(ii) *Adjusted basis.* As a result of reversing the transaction under paragraph (b)(7)(i) of this section, a taxpayer will have an adjusted basis in the retained property equal to the cumulative allocable contract costs reported under the contract in all prior taxable years. However, if the taxpayer received and retains any consideration or compensation from the customer, the taxpayer must reduce the adjusted basis in the retained property (but not below zero) by the fair market value of that consideration or compensation. To the extent that the amount of the consideration or compensation described in the preceding sentence exceeds the adjusted basis in the retained property, the taxpayer must include the excess in gross income for the taxable year of termination.

(iii) *Look-back method.* The look-back method does not apply to a terminated contract that is subject to this paragraph (b)(7).

(c) *Exempt contract methods*—(1) *In general.* An *exempt contract method* means the method of accounting that a

taxpayer must use to account for all its long-term contracts (and any portion of a long-term contract) that are exempt from the requirements of section 460(a). Thus, an exempt contract method applies to exempt construction contracts, as defined in § 1.460–3(b); the non-PCM portion of a qualified ship contract, as defined in § 1.460–2(d); and the non-PCM portion of a residential construction contract, as defined in § 1.460–3(c). Permissible exempt contract methods include the PCM, the EPCM described in paragraph (c)(2) of this section, the CCM described in paragraph (d) of this section, or any other permissible method. See section 446.

(2) *Exempt-contract percentage-of-completion method*—(i) *In general.* Similar to the PCM described in paragraph (b) of this section, a taxpayer using the EPCM generally must include in income the portion of the total contract price, as described in paragraph (b)(4) of this section, that corresponds to the percentage of the entire contract that the taxpayer has completed during the taxable year. However, under the EPCM, the percentage of completion may be determined as of the end of the taxable year by using any method of cost comparison (such as comparing direct labor costs incurred to date to estimated total direct labor costs) or by comparing the work performed on the contract with the estimated total work to be performed, rather than by using the cost-to-cost comparison required by paragraphs (b)(2)(i) and (5) of this section, provided such method is used consistently and clearly reflects income. In addition, paragraph (b)(3) of this section (regarding post-completion-year income), paragraph (b)(6) of this section (regarding the 10-percent method) and § 1.460–6 (regarding the look-back method) do not apply to the EPCM.

(ii) *Determination of work performed.* For purposes of the EPCM, the criteria used to compare the work performed on a contract as of the end of the taxable year with the estimated total work to be performed must clearly reflect the earning of income with respect to the contract. For example, in the case of a roadbuilder, a standard of completion solely based on miles of roadway completed in a case where the terrain is substantially different may not clearly reflect the earning of income with respect to the contract.

(d) *Completed-contract method*—(1) *In general.* Except as otherwise provided in paragraph (d)(4) of this section, a taxpayer using the CCM to account for a long-term contract must take into account in the contract's completion year, as defined in § 1.460–1(b)(6), the gross contract price and all allocable contract costs incurred by the completion year. A taxpayer may not treat the cost of any materials and supplies that are allocated to a contract, but actually remain on hand when the contract is completed, as an allocable contract cost.

(2) *Post-completion-year income and costs.* If a taxpayer has not included an item of contingent compensation (*i.e.*, amounts for which the all events test has not been satisfied) in gross contract price under paragraph (d)(3) of this section by the completion year, the taxpayer must account for this item of contingent compensation using a permissible method of accounting. If a taxpayer incurs an allocable contract cost after the completion year, the taxpayer must account for that cost using a permissible method of accounting.

(3) *Gross contract price.* Gross contract price includes all amounts (including holdbacks, retainages, and reimbursements) that a taxpayer is entitled by law or contract to receive, whether or not the amounts are due or have been paid. In addition, gross contract price includes all bonuses, awards, and incentive payments, such as a bonus for meeting an early completion date, to the extent the all events test is satisfied. If a taxpayer performs a non-long-term contract activity, as defined in § 1.460–1(d)(2), that is incident to or necessary for the manufacture, building, installation, or construction of the subject matter of one or more of the taxpayer's long-term contracts, the taxpayer must include an allocable share of the gross receipts attributable to that activity in the gross contract price of the contract(s) benefitted by that activity. Gross contract price also includes amounts reimbursed for independent research and development expenses (as defined in § 1.460–1(b)(9)), or bidding and proposal costs, under a federal or cost-plus long-term contract (as defined in section 460(d)), regardless of whether the research and development, or bidding and proposal, activities are incident to or necessary for the performance of that long-term contract.

(4) *Contracts with disputed claims*—(i) *In general.* The special rules in this paragraph (d)(4) apply to a long-term contract accounted for using the CCM with a dispute caused by a customer's requesting a reduction of the gross contract price or the performance of additional work under the contract or by a taxpayer's requesting an increase in gross contract price, or both, on or after the date a taxpayer has tendered the subject matter of the contract to the customer.

(ii) *Taxpayer assured of profit or loss.* If the disputed amount relates to a customer's claim for either a reduction in price or additional work and the taxpayer is assured of either a profit or a loss on a long-term contract regardless of the outcome of the dispute, the gross contract price, reduced (but not below zero) by the amount reasonably in dispute, must be taken into account in the completion year. If the disputed amount relates to a taxpayer's claim for an increase in price and the taxpayer is assured of either a profit or a loss on a long-term contract regardless of the outcome of the dispute, the gross contract price must be taken into account in the completion year. If the taxpayer is assured a profit on the contract, all allocable contract costs incurred by the end of the completion year are taken into account in that year. If the taxpayer is assured a loss on the contract, all allocable contract costs incurred by the end of the completion year, reduced by the amount reasonably in dispute, are taken into account in the completion year.

(iii) *Taxpayer unable to determine profit or loss.* If the amount reasonably in dispute affects so much of the gross contract price or allocable contract costs that a taxpayer cannot determine whether a profit or loss ultimately will be realized from a long-term contract, the taxpayer may not take any of the gross contract price or allocable contract costs into account in the completion year.

(iv) *Dispute resolved.* Any part of the gross contract price and any allocable contract costs that have not been taken into account because of the principles described in paragraph (d)(4)(i), (ii), or (iii) of this section must be taken into account in the taxable year in which the dispute is resolved. If a taxpayer performs additional work under the contract because of the dispute, the term *taxable year in which the dispute is resolved* means the taxable year the additional work is completed, rather than the taxable year in which the outcome of the dispute is determined by agreement, decision, or otherwise.

(e) *Percentage-of-completion/capitalized-cost method.* Under the PCCM, a taxpayer must determine the income from a long-term contract using the PCM for the applicable percentage of the contract and its exempt contract method, as defined in paragraph (c) of this section, for the remaining percentage of the contract. For residential construction contracts described in § 1.460–3(c), the applicable percentage is 70 percent, and the

remaining percentage is 30 percent. For qualified ship contracts described in § 1.460–2(d), the applicable percentage is 40 percent, and the remaining percentage is 60 percent.

(f) *Alternative minimum taxable income*—(1) *In general.* Under section 56(a)(3), a taxpayer (not exempt from the AMT under section 55(e)) must use the PCM to determine its AMTI from any long-term contract entered into on or after March 1, 1986, that is not a home construction contract, as defined in § 1.460–3(b)(2). For AMTI purposes, the PCM must include any election under paragraph (b)(6) of this section (concerning the 10-percent method) or under § 1.460–5(c) (concerning the simplified cost-to-cost method) that the taxpayer has made for regular tax purposes. For exempt construction contracts described in § 1.460–3(b)(1)(ii), a taxpayer must use the simplified cost-to-cost method to determine the completion factor for AMTI purposes. Except as provided in paragraph (f)(2) of this section, a taxpayer must use AMTI costs and AMTI methods, such as the depreciation method described in section 56(a)(1), to determine the completion factor of a long-term contract (except a home construction contract) for AMTI purposes.

(2) *Election to use regular completion factors.* Under this paragraph (f)(2), a taxpayer may elect for AMTI purposes to determine the completion factors of all of its long-term contracts using the methods of accounting and allocable contract costs used for regular federal income tax purposes. A taxpayer makes this election by using regular methods and regular costs to compute the completion factors of all long-term contracts entered into during the taxable year of the election for AMTI purposes on its original federal income tax return for the election year. This election is a method of accounting and, thus, applies to all long-term contracts entered into during and after the taxable year of the election. Although a taxpayer may elect to compute the completion factor of its long-term contracts using regular methods and regular costs, an election under this paragraph (f)(2) does not eliminate a taxpayer's obligation to comply with the requirements of section 55 when computing AMTI. For example, although a taxpayer may elect to use the depreciation methods used for regular tax purposes to compute the completion factor of its long-term contracts for AMTI purposes, the taxpayer must use the depreciation methods permitted by section 56 to compute AMTI.

(g) *Method of accounting.* A taxpayer that uses the PCM, EPCM, CCM, PCCM, or elects the 10-percent method or special AMTI method (or changes to another method of accounting with the Commissioner's consent) must apply the method(s) consistently for all similarly classified long-term contracts, until the taxpayer obtains the Commissioner's consent under section 446(e) to change to another method of accounting. A taxpayer-initiated change in method of accounting will be permitted only on a cut-off basis (*i.e.*, for contracts entered into on or after the year of change), and thus, a section 481(a) adjustment will not be permitted or required.

(h) *Examples.* The following examples illustrate the rules of this section:

Example 1. PCM—estimating total contract price. C, whose taxable year ends December 31, determines the income from long-term contracts using the PCM. On January 1, 2001, C enters into a contract to design and manufacture a satellite (a unique item). The contract provides that C will be paid $10,000,000 for delivering the completed satellite by December 1, 2002. The contract also provides that C will receive a $3,000,000 bonus for delivering the satellite by July 1, 2002, and an additional $4,000,000 bonus if the satellite successfully performs its mission for five years. C is unable to reasonably predict if the satellite will successfully perform its mission for five years. If on December 31, 2001, C should reasonably expect to deliver the satellite by July 1, 2002, the estimated total contract price is $13,000,000 ($10,000,000 unit price + $3,000,000 production-related bonus). Otherwise, the estimated total contract price is $10,000,000. In either event, the $4,000,000 bonus is not includible in the estimated total contract price as of December 31, 2001, because C is unable to reasonably predict that the satellite will successfully perform its mission for five years.

Example 2. PCM—computing income. (i) C, whose taxable year ends December 31, determines the income from long-term contracts using the PCM. During 2001, C agrees to manufacture for the customer, B, a unique item for a total contract price of $1,000,000. Under C's contract, B is entitled to retain 10 percent of the total contract price until it accepts the item. By the end of 2001, C has incurred $200,000 of allocable contract costs and estimates that the total allocable contract costs will be $800,000. By the end of 2002, C has incurred $600,000 of allocable contract costs and estimates that the total allocable contract costs will be $900,000. In 2003, after completing the contract, C determines that the actual cost to manufacture the item was $750,000.

(ii) For each of the taxable years, C's income from the contract is computed as follows:

	Taxable Year		
	2001	2002	2003
(A) Cumulative incurred costs	$200,000	$600,000	$750,000
(B) Estimated total costs	800,000	900,000	750,000
(C) Completion factor: (A) ÷ (B)	25.00%	66.67%	100.00%
(D) Total contract price	1,000,000	1,000,000	1,000,000
(E) Cumulative gross receipts: (C) × (D)	250,000	666,667	1,000,000
(F) Cumulative gross receipts (prior year)	(0)	(250,000)	(666,667)
(G) Current-year gross receipts	250,000	416,667	333,333
(H) Cumulative incurred costs	200,000	600,000	750,000
(I) Cumulative incurred costs (prior year)	(0)	(200,000)	(600,000)
(J) Current-year costs	200,000	400,000	150,000
(K) Gross income: (G) − (J)	$50,000	$16,667	$183,333

Example 3. PCM—computing income with cost sharing. (i) C, whose taxable year ends December 31, determines the income from long-term contracts using the PCM. During 2001, C enters into a contract to manufacture a unique item. The contract specifies a target price of $1,000,000, a target cost of $600,000, and a target profit of $400,000. C and B will share the savings of any cost underrun (actual total incurred cost is less than target cost) and the additional cost of any cost overrun (actual total incurred cost is greater than target cost) as follows: 30 percent to C and 70 percent to B. By the end of 2001, C has incurred $200,000 of allocable contract costs and estimates that the total allocable contract costs will be $600,000. By the end of 2002, C has incurred $300,000 of allocable contract costs and estimates that the total allocable contract costs will be $400,000. In 2003, after completing the contract, C determines that the actual cost to manufacture the item was $700,000.

(ii) For each of the taxable years, C's income from the contract is computed as follows (note that the sharing of any cost underrun or cost overrun is reflected as an adjustment to C's target price under paragraph (b)(4)(i) of this section):

	Taxable Year		
	2001	2002	2003
(A) Cumulative incurred costs	$200,000	$300,000	$700,000
(B) Estimated total costs	600,000	400,000	700,000
(C) Completion factor: (A) ÷ (B)	33.33%	75.00%	100.00%
(D) Target price	$1,000,000	$1,000,000	$1,000,000
(E) Estimated total costs	600,000	400,000	700,000
(F) Target costs	600,000	600,000	600,000
(G) Cost (underrun)/overrun: (E) − (F)	0	(200,000)	100,000
(H) Adjustment rate	70%	70%	70%
(I) Target price adjustment	0	(140,000)	70,000
(J) Total contract price: (D) + (I)	$1,000,000	$860,000	$1,070,000
(K) Cumulative gross receipts: (C) × (J)	$333,333	$645,000	$1,070,000
(L) Cumulative gross receipts (prior year):	(0)	(333,333)	(645,000)
(M) Current-year gross receipts	333,333	311,667	425,000
(N) Cumulative incurred costs	200,000	300,000	700,000
(O) Cumulative incurred costs (prior year):	(0)	(200,000)	(300,000)
(P) Current-year costs	200,000	100,000	400,000
(Q) Gross income: (M) − (P)	$133,333	$211,667	$25,000

Example 4. PCM—10 percent method. (i) C, whose taxable year ends December 31, determines the income from long-term contracts using the PCM. In November 2001, C agrees to manufacture a unique item for $1,000,000. C reasonably estimates that the total allocable contract costs will be $600,000. By December 31, 2001, C has received $50,000 in progress payments and incurred $40,000 of costs. C elects to use the 10 percent method effective for 2001 and all subsequent taxable years. During 2002, C receives $500,000 in progress payments and incurs $260,000 of costs. In 2003, C incurs an additional $300,000 of costs, C finishes manufacturing the item, and receives the final $450,000 payment.

(ii) For each of the taxable years, C's income from the contract is computed as follows:

	Taxable Year		
	2001	2002	2003
(A) Cumulative incurred costs	$40,000	$300,000	$600,000
(B) Estimated total costs	600,000	600,000	600,000
(C) Completion factor (A) ÷ (B)	6.67%	50.00%	100.00%
(D) Total contract price	1,000,000	1,000,000	1,000,000
(E) Cumulative gross receipts: (C) × (D)*	0	500,000	1,000,000
(F) Cumulative gross receipts (prior year):	(0)	(0)	(500,000)
(G) Current-year gross receipts	0	500,000	500,000
(H) Cumulative incurred costs	0	300,000	600,000
(I) Cumulative incurred costs (prior year):	(0)	(0)	(300,000)
(J) Current-year costs	0	300,000	300,000
(K) Gross income: (G) − (J)	$0	$200,000	$200,000

*Unless (C) <10 percent.

Example 5. PCM—contract terminated. C, whose taxable year ends December 31, determines the income from long-term contracts using the PCM. During 2001, C buys land and begins constructing a building that will contain 50 condominium units on that land. C enters into a contract to sell one unit in this condominium to B for $240,000. B gives C a $5,000 deposit toward the purchase price. By the end of 2001, C has incurred $50,000 of allocable contract costs on B's unit and estimates that the total allocable contract costs on B's unit will be $150,000. Thus, for 2001, C reports gross receipts of $80,000 ($50,000 ÷ $150,000 × $240,000), current-year costs of $50,000, and gross income of $30,000 ($80,000—$50,000). In 2002, after C has incurred an additional $25,000 of allocable contract costs on B's unit, B files for bankruptcy protection and defaults on the contract with C, who is permitted to keep B's $5,000 deposit as liquidated damages. In 2002, C reverses the transaction with B under paragraph (b)(7) of this section and reports a loss of $30,000 ($50,000–$80,000). In addition, C obtains an adjusted basis in the unit sold to B of $70,000 ($50,000 (current-year costs deducted in 2001)—$5,000 (B's forfeited deposit) + $25,000 (current-year costs incurred in 2002). C may not apply the look-back method to this contract in 2002.

Example 6. CCM—contracts with disputes from customer claims. In 2001, C, whose taxable year ends December 31, uses the CCM to account for exempt construction contracts. C enters into a contract to construct a bridge for B. The terms of the contract provide for a $1,000,000 gross contract price. C finishes the bridge in 2002 at a cost of $950,000. When B examines the bridge, B insists that C either repaint several girders or reduce the contract price. The amount reasonably in dispute is $10,000. In 2003, C and B resolve their dispute, C repaints the girders at a cost of $6,000, and C and B agree that the contract price is not to be reduced. Because C is assured a profit of $40,000 ($1,000,000—$10,000—$950,000) in 2002 even if the dispute is resolved in B's favor, C must take this $40,000 into account in 2002. In 2003, C will earn an additional $4,000 profit ($1,000,000—$956,000—$40,000) from the contract with B. Thus, C must take into account an additional $10,000 of gross contract price and $6,000 of additional contract costs in 2003.

Example 7. CCM—contracts with disputes from taxpayer claims. In 2003, C, whose taxable year ends December 31, uses the CCM to account for exempt construction contracts. C enters into a contract to construct a building for B. The terms of the contract provide for a $1,000,000 gross contract price. C finishes the building in 2004 at a cost of $1,005,000. B examines the building in 2004 and agrees that it meets the contract's specifications; however, at the end of 2004, C and B are unable to agree on the merits of C's claim for an additional $10,000 for items that C alleges are changes in contract specifications and B alleges are within the scope of the contract's original specifications. In 2005, B agrees to pay C an additional $2,000 to satisfy C's claims under the contract. Because the amount in dispute affects so much of the gross contract price that C cannot determine in 2004 whether a profit or loss will ultimately be realized, C may not taken any of the gross contract price or allocable contract costs into account in 2004. C must take into account $1,002,000 of gross contract price and $1,005,000 of allocable contract costs in 2005.

Example 8. CCM—contracts with disputes from taxpayer and customer claims. C, whose taxable year ends December 31, uses the CCM to account for exempt construction contracts. C constructs a factory for B pursuant to a long-term contract. Under the terms of the contract, B agrees to pay C a total of $1,000,000 for construction of the factory. C finishes construction of the factory in 2002 at a cost of $1,020,000. When B takes possession of the factory and begins operations in December 2002, B is dissatisfied with the location and workmanship of certain heating ducts. As of the end of 2002, C contends that the heating ducts are constructed in accordance with contract specifications. The amount of the gross contract price reasonably in dispute with respect to the heating ducts is $6,000. As of this time, C is claiming $14,000 in addition to the original contract price for certain changes in contract specifications which C alleges have increased his costs. B denies that these changes have increased C's costs. In 2003, the disputes between C and B are resolved by performance of additional work by C at a cost of $1,000 and by an agreement that the contract price would be revised downward to $996,000. Under these circumstances, C must include in his gross income for 2002, $994,000 (the gross contract price less the amount reasonably in dispute because of B's claim, or $1,000,000—$6,000). In 2002, C must also take into account $1,000,000 of allocable contract costs (costs incurred less the amounts in dispute attributable to both B's and C's claims, or $1,020,000—$6,000—$14,000). In 2003, C must take into account an additional $2,000 of gross contract price ($996,000—$994,000) and $21,000 of allocable contract costs ($1,021,000—$1,000,000).

(i) [Reserved]

* * * * *

(k) *Mid-contract change in taxpayer.* [Reserved]

Par. 8. Section 1.460–5 is added to read as follows:

§ 1.460–5 Cost allocation rules.

(a) *Overview.* This section prescribes methods of allocating costs to long-term contracts accounted for using the percentage-of-completion method described in § 1.460–4(b) (PCM), the completed-contract method described in § 1.460–4(d) (CCM), or the percentage-of-completion/capitalized-cost method described in § 1.460–4(e) (PCCM). Exempt construction contracts described in § 1.460–3(b) accounted for using a method other than the PCM or CCM are not subject to the cost allocation rules of this section (other than the requirement to allocate production-period interest under paragraph (b)(2)(v) of this section). Paragraph (b) of this section describes the regular cost allocation methods for contracts subject to the PCM. Paragraph (c) of this section describes an elective simplified cost allocation method for contracts subject to the PCM. Paragraph (d) of this section describes the cost allocation methods for exempt construction contracts reported using the CCM. Paragraph (e) of this section describes the cost allocation rules for contracts subject to the PCCM. Paragraph (f) of this section describes additional rules applicable to the cost allocation methods described in this section. Paragraph (g) of this section provides rules concerning consistency in method of allocating costs to long-term contracts.

(b) *Cost allocation method for contracts subject to PCM*—(1) *In general.* Except as otherwise provided in paragraph (b)(2) of this section, a taxpayer must allocate costs to each long-term contract subject to the PCM in the same manner that direct and indirect costs are capitalized to property produced by a taxpayer under § 1.263A–1(e) through (h). Thus, a taxpayer must allocate to each long-term contract subject to the PCM all direct costs and certain indirect costs properly allocable to the long-term contract (*i.e.*, all costs that directly benefit or are incurred by reason of the performance of the long-term contract). However, see paragraph (c) of this section concerning an election to allocate contract costs using the simplified cost-to-cost method. As in section 263A, the use of the practical capacity concept is not permitted. See § 1.263A–2(a)(4).

(2) *Special rules*—(i) *Direct material costs.* The costs of direct materials must be allocated to a long-term contract when dedicated to the contract under principles similar to those in § 1.263A–11(b)(2). Thus, a taxpayer dedicates direct materials by associating them with a specific contract, including by purchase order, entry on books and records, or shipping instructions. A taxpayer maintaining inventories under § 1.471–1 must determine allocable contract costs attributable to direct materials using its method of accounting for those inventories (*e.g.*, FIFO, LIFO, specific identification).

(ii) *Components and subassemblies.* The costs of a component or subassembly (component) produced by the taxpayer must be allocated to a long-term contract as the taxpayer incurs costs to produce the component if the taxpayer reasonably expects to incorporate the component into the subject matter of the contract. Similarly,

the cost of a purchased component (including a component purchased from a related party) must be allocated to a long-term contract as the taxpayer incurs the cost to purchase the component if the taxpayer reasonably expects to incorporate the component into the subject matter of the contract. In all other cases, the cost of a component must be allocated to a long-term contract when the component is dedicated, under principles similar to those in § 1.263A–11(b)(2). A taxpayer maintaining inventories under § 1.471–1 must determine allocable contract costs attributable to components using its method of accounting for those inventories (*e.g.*, FIFO, LIFO, specific identification).

(iii) *Simplified production methods.* A taxpayer may not determine allocable contract costs using the simplified production methods described in § 1.263A–2(b) and (c).

(iv) *Costs identified under cost-plus long-term contracts and federal long-term contracts.* To the extent not otherwise allocated to the contract under this paragraph (b), a taxpayer must allocate any identified costs to a cost-plus long-term contract or federal long-term contract (as defined in section 460(d)). *Identified cost* means any cost, including a charge representing the time-value of money, identified by the taxpayer or related person as being attributable to the taxpayer's cost-plus long-term contract or federal long-term contract under the terms of the contract itself or under federal, state, or local law or regulation.

(v) *Interest*—(A) *In general.* If property produced under a long-term contract is *designated property*, as defined in § 1.263A–8(b) (without regard to the exclusion for long-term contracts under § 1.263A–8(d)(2)(v)), a taxpayer must allocate interest incurred during the production period to the long-term contract in the same manner as interest is allocated to property produced by a taxpayer under section 263A(f). See §§ 1.263A–8 to 1.263A–12 generally.

(B) *Production period.* Notwithstanding § 1.263A–12(c) and (d), for purposes of this paragraph (b)(2)(v), the production period of a long-term contract—

(*1*) Begins on the later of—

(*i*) The contract commencement date, as defined in § 1.460–1(b)(7); or

(*ii*) For a taxpayer using the accrual method of accounting for long-term contracts, the date by which 5 percent or more of the total estimated costs, including design and planning costs, under the contract have been incurred; and

(*2*) Ends on the date that the contract is completed, as defined in § 1.460–1(c)(3).

(C) *Application of section 263A(f).* For purposes of this paragraph (b)(2)(v), section 263A(f)(1)(B)(iii) (regarding an estimated production period exceeding 1 year and a cost exceeding $1,000,000) must be applied on a contract-by-contract basis; except that, in the case of a taxpayer using an accrual method of accounting, that section must be applied on a property-by-property basis.

(vi) *Research and experimental expenses.* Notwithstanding § 1.263A–1(e)(3)(ii)(P) and (iii)(B), a taxpayer must allocate research and experimental expenses, other than independent research and development expenses (as defined in § 1.460–1(b)(9)), to its long-term contracts.

(vii) *Service costs*—(A) *Simplified service cost method*—(1) *In general.* To use the simplified service cost method under § 1.263A–1(h), a taxpayer must allocate the otherwise capitalizable mixed service costs among its long-term contracts using a reasonable method. For example, otherwise capitalizable mixed service costs may be allocated to each long-term contract based on labor hours or contract costs allocable to the contract. To be considered reasonable, an allocation method must be applied consistently and must not disproportionately allocate service costs to contracts expected to be completed in the near future.

(2) *Example.* The following example illustrates the rule of this paragraph (b)(2)(vii)(A):

Example. Simplified service cost method. During 2001, C, whose taxable year ends December 31, produces electronic equipment for inventory and enters into long-term contracts to manufacture specialized electronic equipment. C's method of allocating mixed service costs to the property it produces is the labor-based, simplified service cost method described in § 1.263A–1(h)(4). For 2001, C's total mixed service costs are $100,000, C's section 263A labor costs are $500,000, C's section 460 labor costs (*i.e.,* labor costs allocable to C's long-term contracts) are $250,000, and C's total labor costs are $1,000,000. To determine the amount of mixed service costs capitalizable under section 263A for 2001, C multiplies its total mixed service costs by its section 263A allocation ratio (section 263A labor costs ÷ total labor costs). Thus, C's capitalizable mixed service costs for 2001 are $50,000 ($100,000 x $500,000 ÷ $1,000,000). Thereafter, C allocates its capitalizable mixed service costs to produced property remaining in ending inventory using its 263A allocation method (*e.g.,* burden rate, simplified production). Similarly, to determine the amount of mixed service costs that are allocable to C's long-term contracts for 2001, C multiplies its total mixed service costs by its section 460 allocation ratio (section 460 labor ÷ total labor costs). Thus, C's allocable mixed service contract costs for 2001 are $25,000 ($100,000 x $250,000 ÷ $1,000,000). Thereafter, C allocates its allocable mixed service costs to its long-term contracts proportionately based on its section 460 labor costs allocable to each long-term contract.

(B) *Jobsite costs.* If an administrative, service, or support function is performed solely at the jobsite for a specific long-term contract, the taxpayer may allocate all the direct and indirect costs of that administrative, service, or support function to that long-term contract. Similarly, if an administrative, service, or support function is performed at the jobsite solely for the taxpayer's long-term contract activities, the taxpayer may allocate all the direct and indirect costs of that administrative, service, or support function among all the long-term contracts performed at that jobsite. For this purpose, jobsite means a production plant or a construction site.

(C) *Limitation on other reasonable cost allocation methods.* A taxpayer may use any other reasonable method of allocating service costs, as provided in § 1.263A–1(f)(4), if, for the taxpayer's long-term contracts considered as a whole, the—

(*1*) Total amount of service costs allocated to the contracts does not differ significantly from the total amount of service costs that would have been allocated to the contracts under § 1.263A–1(f)(2) or (3);

(*2*) Service costs are not allocated disproportionately to contracts expected to be completed in the near future because of the taxpayer's cost allocation method; and

(*3*) Taxpayer's cost allocation method is applied consistently.

(c) *Simplified cost-to-cost method for contracts subject to the PCM*—(1) *In general.* Instead of using the cost allocation method prescribed in paragraph (b) of this section, a taxpayer may elect to use the simplified cost-to-cost method, which is authorized under section 460(b)(3)(A), to allocate costs to a long-term contract subject to the PCM. Under the simplified cost-to-cost method, a taxpayer determines a contract's completion factor based upon only direct material costs; direct labor costs; and depreciation, amortization, and cost recovery allowances on equipment and facilities directly used to manufacture or construct the subject matter of the contract. For this purpose, the costs associated with any manufacturing or construction activities performed by a subcontractor are considered either direct material or direct labor costs, as appropriate, and

therefore must be allocated to the contract under the simplified cost-to-cost method. An electing taxpayer must use the simplified cost-to-cost method to apply the look-back method under § 1.460–6 and to determine alternative minimum taxable income under § 1.460–4(f).

(2) *Election.* A taxpayer makes an election under this paragraph (c) by using the simplified cost-to-cost method for all long-term contracts entered into during the taxable year of the election on its original federal income tax return for the election year. This election is a method of accounting and, thus, applies to all long-term contracts entered into during and after the taxable year of the election. This election is not available if a taxpayer does not use the PCM to account for all long-term contracts or if a taxpayer elects to use the 10-percent method described in § 1.460–4(b)(6).

(d) *Cost allocation rules for exempt construction contracts reported using the CCM*—(1) *In general.* For exempt construction contracts reported using the CCM, other than contracts described in paragraph (d)(3) of this section (concerning contracts of homebuilders that do not satisfy the $10,000,000 gross receipts test described in § 1.460–3(b)(3) or will not be completed within two years of the contract commencement date), a taxpayer must annually allocate the cost of any activity that is incident to or necessary for the taxpayer's performance under a long-term contract. A taxpayer must allocate to each exempt construction contract all direct costs as defined in § 1.263A–1(e)(2)(i) and all indirect costs either as provided in § 1.263A–1(e)(3) or as provided in paragraph (d)(2) of this section.

(2) *Indirect costs*—(i) *Indirect costs allocable to exempt construction contracts.* A taxpayer allocating costs under this paragraph (d)(2) must allocate the following costs to an exempt construction contract, other than a contract described in paragraph (d)(3) of this section, to the extent incurred in the performance of that contract—

(A) Repair of equipment or facilities;

(B) Maintenance of equipment or facilities;

(C) Utilities, such as heat, light, and power, allocable to equipment or facilities;

(D) Rent of equipment or facilities;

(E) Indirect labor and contract supervisory wages, including basic compensation, overtime pay, vacation and holiday pay, sick leave pay (other than payments pursuant to a wage continuation plan under section 105(d) as it existed prior to its repeal in 1983), shift differential, payroll taxes, and contributions to a supplemental unemployment benefits plan;

(F) Indirect materials and supplies;

(G) Noncapitalized tools and equipment;

(H) Quality control and inspection;

(I) Taxes otherwise allowable as a deduction under section 164, other than state, local, and foreign income taxes, to the extent attributable to labor, materials, supplies, equipment, or facilities;

(J) Depreciation, amortization, and cost-recovery allowances reported for the taxable year for financial purposes on equipment and facilities to the extent allowable as deductions under chapter 1 of the Internal Revenue Code;

(K) Cost depletion;

(L) Administrative costs other than the cost of selling or any return on capital;

(M) Compensation paid to officers other than for incidental or occasional services;

(N) Insurance, such as liability insurance on machinery and equipment; and

(O) Interest, as required under paragraph (b)(2)(v) of this section.

(ii) *Indirect costs not allocable to exempt construction contracts.* A taxpayer allocating costs under this paragraph (d)(2) is not required to allocate the following costs to an exempt construction contract reported using the CCM—

(A) Marketing and selling expenses, including bidding expenses;

(B) Advertising expenses;

(C) Other distribution expenses;

(D) General and administrative expenses attributable to the performance of services that benefit the taxpayer's activities as a whole (*e.g.,* payroll expenses, legal and accounting expenses);

(E) Research and experimental expenses (described in section 174 and the regulations thereunder);

(F) Losses under section 165 and the regulations thereunder;

(G) Percentage of depletion in excess of cost depletion;

(H) Depreciation, amortization, and cost recovery allowances on equipment and facilities that have been placed in service but are temporarily idle (for this purpose, an asset is not considered to be temporarily idle on non-working days, and an asset used in construction is considered to be idle when it is neither en route to nor located at a job-site), and depreciation, amortization and cost recovery allowances under chapter 1 of the Internal Revenue Code in excess of depreciation, amortization, and cost recovery allowances reported by the taxpayer in the taxpayer's financial reports;

(I) Income taxes attributable to income received from long-term contracts;

(J) Contributions paid to or under a stock bonus, pension, profit-sharing, or annuity plan or other plan deferring the receipt of compensation whether or not the plan qualifies under section 401(a), and other employee benefit expenses paid or accrued on behalf of labor, to the extent the contributions or expenses are otherwise allowable as deductions under chapter 1 of the Internal Revenue Code. Other employee benefit expenses include (but are not limited to): Worker's compensation; amounts deductible or for whose payment reduction in earnings and profits is allowed under section 404A and the regulations thereunder; payments pursuant to a wage continuation plan under section 105(d) as it existed prior to its repeal in 1983; amounts includible in the gross income of employees under a method or arrangement of employer contributions or compensation which has the effect of a stock bonus, pension, profit-sharing, or annuity plan, or other plan deferring the receipt of compensation or providing deferred benefits; premiums on life and health insurance; and miscellaneous benefits provided for employees such as safety, medical treatment, recreational and eating facilities, membership dues, *etc.*;

(K) Cost attributable to strikes, rework labor, scrap and spoilage; and

(L) Compensation paid to officers attributable to the performance of services that benefit the taxpayer's activities as a whole.

(3) *Large homebuilders.* A taxpayer must capitalize the costs of home construction contracts under section 263A and the regulations thereunder, unless the contract will be completed within two years of the contract commencement date and the taxpayer satisfies the $10,000,000 gross receipts test described in § 1.460–3(b)(3).

(e) *Cost allocation rules for contracts subject to the PCCM.* A taxpayer must use the cost allocation rules described in paragraph (b) of this section to determine the costs allocable to the entire qualified ship contract or residential construction contract accounted for using the PCCM and may not use the simplified cost-to-cost method described in paragraph (c) of this section.

(f) *Special rules applicable to costs allocated under this section*—(1) *Nondeductible costs.* A taxpayer may not allocate any otherwise allocable contract cost to a long-term contract if any section of the Internal Revenue Code disallows a deduction for that type of payment or expenditure (*e.g.,* an illegal bribe described in section 162(c)).

(2) *Costs incurred for non-long-term contract activities.* If a taxpayer performs a non-long-term contract activity, as defined in § 1.460–1(d)(2), that is incident to or necessary for the manufacture, building, installation, or construction of the subject matter of one or more of the taxpayer's long-term contracts, the taxpayer must allocate the costs attributable to that activity to such contract(s).

(g) *Method of accounting.* A taxpayer that adopts or elects a cost allocation method of accounting (or changes to another cost allocation method of accounting with the Commissioner's consent) must apply that method consistently for all similarly classified contracts, until the taxpayer obtains the Commissioner's consent under section 446(e) to change to another cost allocation method. A taxpayer-initiated change in cost allocation method will be permitted only on a cut-off basis (*i.e.,* for contracts entered into on or after the year of change) and thus, a section 481(a) adjustment will not be permitted or required.

Par. 9. Section 1.460–6 is amended as follows:

1. A sentence is added to the end of paragraph (a)(2).

2. The third sentence of paragraph (b)(1) is removed.

3. In the fourth sentence of paragraph (b)(1), ''Therefore, to the extent that the percentage of completion method is required to be used'' is removed and ''To the extent that the percentage of completion method is required to be used under § 1.460–1(g)'' is added in its place.

4. The first sentence of paragraph (c)(1)(ii)(A) is revised.

5. In the first sentence of paragraph (c)(1)(ii)(B), the language ''no later than the year'' is removed and ''in the year'' is added in its place and ''§ 1.451–3(b)(*2*)'' is removed and ''§ 1.460–1(c)(3)'' is added in its place.

6. The last two sentences of paragraph (c)(1)(ii)(B) are removed.

7. In the last sentence of paragraph (c)(1)(ii)(C)(*2*), the language ''§ 5h.6'' is removed and ''§ 301.9100–8 of this chapter'' is added in its place.

8. In the fourth sentence of paragraph (c)(2)(v)(A), the language ''similarly'' is removed.

9. The first, second, fifth, and sixth sentences of paragraph (c)(2)(v)(A) are removed.

10. In the first sentence of paragraph (c)(2)(vi)(B), the language ''§ 1.453(b)(2)(ii), (iii), (iv), and § 1.451–3(d)(2), (3), and (4)'' is removed and ''§ 1.460–4(b)(4)(i)'' is added in its place.

11. In the second sentence of paragraph (c)(2)(vi)(B), the language ''the percentage of completion method and'' is removed.

12. In the third sentence of paragraph (c)(2)(vi)(B), the language '', for purposes of both the percentage of completion method and the look-back method'' is removed.

13. In the fourth sentence of paragraph (c)(2)(vi)(B), the language ''Similarly, a'' is removed and ''A'' is added in its place.

14. In the first sentence of paragraph (c)(2)(vi)(C), the language ''§ 1.451–3(e)'' is removed and ''§ 1.460–1(e)'' is added in its place.

15. Paragraph (c)(4)(iv) is removed.

16. In the first sentence of paragraph (d)(4)(ii)(C), the language ''within the meaning of section 1504(a)'' is removed and '', as defined in § 1.1502–1(h)'' is added in its place.

17. In the fourth sentence of paragraph (e)(2), the language ''within the meaning of section 1504(a)'' is removed and '', as defined in § 1.1502–1(h)'' is added in its place.

18. In the first sentence of paragraph (f)(1), the language ''or to be refunded'' is removed and ''from, or payable to, a taxpayer'' is added in its place.

19. In the first sentence of paragraph (f)(1), the language ''and reported'' is removed.

20. In the second sentence of paragraph (f)(1), the language ''and Form 8697 is filed by'' is removed.

21. In the second sentence of paragraph (f)(2)(i), the language ''fails to file Form 8697 with respect to interest required to be paid or that'' is removed.

22. In the second sentence of paragraph (f)(2)(i), the language ''a penalty for failing to file Form 8697'' is removed and ''an underpayment penalty under section 6651, and the taxpayer also is liable for underpayment interest under section 6601'' is added in its place.

23. In the third sentence of paragraph (f)(2)(i), the language ''penalty'' is removed and ''subtitle F'' is added in its place.

24. In the fourth sentence of paragraph (f)(2)(i), the language ''or a tax refund'' is added after ''liability''.

25. In the first sentence of paragraph (f)(2)(ii), the language ''refunded'' is removed and ''payable'' is added in its place.

26. Paragraph (f)(3) is added.

The revisions and additions read as follows:

§ 1.460–6 Look-back method.

(a) * * *

(2) * * * Paragraph (j) of this section provides guidance concerning the election not to apply the look-back method in de minimis cases.

* * * * *

(c) * * * (1) * * *

(ii) * * * (A) *In general.* Except as otherwise provided in section 460(b)(6) (see § 1.460–6(j) for method of electing) or § 1.460–6(e), a taxpayer must apply the look-back method to a long-term contract in the completion year and in any post-completion year for which the taxpayer must adjust total contract price or total allocable contract costs, or both, under the PCM. * * *

* * * * *

(f) * * *

(3) *Statute of limitations and compounding of interest on look-back interest.* For guidance on the statute of limitations applicable to the assessment and collection of look-back interest owed by a taxpayer, see sections 6501 and 6502. A taxpayer's claim for credit or refund of look-back interest previously paid by or collected from a taxpayer is a claim for credit or refund of an overpayment of tax and is subject to the statute of limitations provided in section 6511. A taxpayer's claim for look-back interest (or interest payable on look-back interest) that is not attributable to an amount previously paid by or collected from a taxpayer is a general, non-tax claim against the federal government. For guidance on the statute of limitations that applies to general, non-tax claims against the federal government, see 28 U.S.C. sections 2401 and 2501. For guidance applicable to the compounding of interest when the look-back interest is not paid, see sections 6601 to 6622.

* * * * *

§§ 1.460–7 and 1.460–8 [Removed]

Par. 10. Sections 1.460–7 and 1.460–8 are removed.

§ 1.471–10 [Amended]

Par. 11. Section 1.471–10 is amended by removing the language ''§ 1.451–3'' and adding ''§ 1.460–2'' in its place.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 12. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 13. In § 602.101, paragraph (b) is amended by:

1. Removing the entry for ''1.451–3''.

2. The following entries are added in numerical order to the table:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
1.460–1	1545–1650
* * * * *	

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 20, 2000.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

[FR Doc. 01–6 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Internal Revenue Service (IRS)

26 CFR Parts 1 and 602

[TD 8933]

RIN 1545–AX33

Qualified Transportation Fringe Benefits

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulation.

SUMMARY: This document contains final regulations relating to qualified transportation fringe benefits. These final regulations provide rules to ensure that transportation benefits provided to employees are excludable from gross income. These final regulations reflect changes to the law made by the Energy Policy Act of 1992, the Taxpayer Relief Act of 1997, and the Transportation Equity Act for the 21st Century. These final regulations affect employers that offer qualified transportation fringes and employees who receive these benefits.

DATES: *Effective Date:* These regulations are effective January 11, 2001.

Applicability Date: For dates of applicability, see § 1.132–9(b), Q/A–25.

FOR FURTHER INFORMATION CONTACT: John Richards, (202) 622–6040 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collection of information contained in these final regulations has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) under control number 1545–1676. Responses to this collection of information are mandatory to obtain the benefit described under section 132(f).

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

The estimated average annual recordkeeping burden per recordkeeper is 26.5 hours. The estimated annual reporting burden per respondent is .8 hours.

Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be sent to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224, and to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503.

Books or records relating to a collection of information must be retained as long as their contents might become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

This document contains amendments to 26 CFR part 1 (Income Tax Regulations). On January 27, 2000, a proposed regulation (REG–113572–99) relating to qualified transportation fringes was published in the **Federal Register** (65 FR 4388). A public hearing was held on June 1, 2000. Written or electronic comments responding to the notice of proposed rulemaking were received. After consideration of all the comments, the proposed regulations are adopted as amended by this Treasury decision. The revisions are discussed below.

Explanation of Provisions and Summary of Comments

In general, comments received on the proposed regulations were favorable and, accordingly, the final regulations retain the general structure of the proposed regulations, including the question and answer format and a variety of examples illustrating the substance of the final regulations. However, commentators made a number of specific recommendations for modifications and clarifications of the regulations. In response to these comments, the final regulations incorporate the modifications and clarifications described below.

A. Whether Vouchers are Readily Available

Section 132(f)(3) provides that qualified transportation fringes include cash reimbursement for transit passes ''only if a voucher or similar item which may be exchanged only for a transit pass is not readily available for direct distribution by the employer to the employee.'' Thus, if vouchers are readily available, the employer must use vouchers and cash reimbursement of a mass transit expense would not be a qualified transportation fringe.

Most of the comments received addressed the issue of whether vouchers are ''readily available.'' Commentators representing employers generally favored rules permitting cash reimbursement. Commentators representing transit operators and voucher providers generally favored rules not permitting cash reimbursement. The following discusses three issues raised by commentators: first, whether the proposed regulations' 1 percent safe harbor should be retained; second, whether internal administrative costs should be considered in applying the 1 percent test; and third, whether other nonfinancial restrictions should be considered in determining whether vouchers are readily available.

1. The 1 Percent Safe Harbor

Under Notice 94–3, 1994–1 C.B. 327, and the proposed regulations, a voucher is readily available if an employer can obtain it on terms no less favorable than those available to an individual employee and without incurring a significant administrative cost. Under the proposed regulations, administrative costs relate only to fees paid to fare media providers, and the determination of whether obtaining a voucher would result in a significant administrative cost is made with respect to each transit system voucher. The proposed regulations provide a rule under which administrative costs are treated as significant if the average monthly administrative costs incurred by the employer for a voucher (disregarding delivery charges imposed by the fare media provider to the extent not in excess of $15 per order) are more than 1 percent of the average monthly value of the vouchers for a system.

Commentators, in particular those representing fare media providers and transit operators, suggested that the fare media provider fee percentage causing vouchers to not be readily available should be raised because many fare media providers charge fees in excess of the 1 percent limit and, thus, under this

test, transit vouchers would not be considered readily available in some large metropolitan areas. These commentators assert that the 1 percent test is therefore contrary to the intent of the statute. Commentators suggested that the 1 percent test, particularly if combined with inadequate cash reimbursement substantiation requirements, may result in taxpayer abuse, with the result that the benefit might not be used for the purpose for which it is intended, which is to increase the use of mass transit. In addition, commentators testified at the public hearing that the mandatory use of vouchers (with no ability to use cash reimbursement if vouchers are readily available) would increase the use of vouchers and promote the development of advanced technologies that minimize the burden on employers while ensuring that the benefit is used for mass transit. These new technologies might allow an employer to make payment directly to the transit operator, who in turn credits fare to the employee's magnetic media fare card, thus eliminating the need for employers to incur the expense of distributing vouchers.

Other commentators, in particular groups representing employers, generally favored the 1 percent test, but suggested that internal costs be considered in applying the test (discussed below). These commentators took the position that an increase in the percentage might affect the market charge for such services. There was also a concern that a strict voucher-use requirement would result in fewer employers adopting transit pass programs, thus frustrating the purpose of section 132(f) to increase the use of mass transit.

The final regulations retain the 1 percent test. The 1 percent test, applicable for years beginning after December 31, 2003, is appropriate in light of the rule (discussed below) that only voucher provider fees are considered in determining availability. It is intended that the delayed application of this rule would provide sufficient time for those affected by this rule to modify their systems and procedures appropriately. The 1 percent threshold, coupled with the exclusion of internal administrative costs from the readily available determination, represents a balanced approach that will promote the growth of voucher programs in most transportation areas. In addition, raising the percentage threshold could curtail the growth in transit benefit programs, which would be contrary to the goal of increasing the use of mass transit. Finally, in cases where cash reimbursement is allowed, adequate substantiation requirements will ensure that transit pass benefits will actually go toward mass transportation usage. In this regard, the proposed regulations provide that employers must implement reasonable procedures to ensure that an amount equal to the reimbursement was incurred for transit passes. For example, the final regulations clarify that in circumstances when employee certification is a reasonable reimbursement procedure, it must occur after the expense is incurred.

The final regulations also clarify the application of the 1 percent rule if multiple vouchers for a transit system are available for distribution by an employer to employees, and if multiple transit system vouchers are required in an area to meet the transit needs of an employer's employees. The final regulations provide that if multiple transit system vouchers are available for direct distribution to employees, the employer must consider the lowest cost voucher for purposes of determining whether the voucher provider fees cause vouchers to not be readily available. However, if multiple vouchers are required in an area to meet the transit needs of the individual employees in that area, the employer has the option of averaging the costs applied to vouchers from each system for purposes of determining whether the voucher provider fees cause vouchers to not be readily available.

2. Internal Administrative Costs

Several commentators representing employers recommended that, in addition to fare media provider fees, internal administrative costs, especially security and distribution costs, should be considered in determining whether vouchers are readily available. These commentators noted that administrative costs are increased when an employer must maintain both a voucher system and a reimbursement system to provide qualified transportation fringes. For example, the employer may maintain a cash reimbursement system for transportation in a commuter highway vehicle and qualified parking, and also maintain a voucher system for transit passes. In addition, several commentators suggested that the increased costs and administrative burden for employers that maintain offices in multiple cities should also be considered in determining whether vouchers are readily available.

The final regulations retain the test considering only fees paid to voucher providers in determining availability based on a plain reading of the terms of the statute. The language ''readily available for direct distribution by the employer to the employee'' under section 132(f)(3) in its plain, ordinary sense means that vouchers are easily obtainable for direct distribution to the employer's employees. The determination of availability bears no relationship with costs that may be incurred after vouchers have been obtained. The service fees charged by voucher providers and delivery costs can reasonably be viewed as affecting whether vouchers are easily obtainable; an employer's internal costs of subsequently administering a voucher program would not. Thus, based upon the plain language of section 132(f), internal administrative costs do not affect whether vouchers are readily available.

Moreover, the test considering only voucher provider fees is a comparatively simple bright line test. A test that depends on the employer's internal administrative costs would necessarily be complex, requiring complex rules that would be difficult for employers to apply.

3. Other Nonfinancial Restrictions

Commentators representing employers suggested that nonfinancial factors should be considered in determining whether vouchers are readily available. They suggested that factors such as whether there are reasonable advance purchase and minimum purchase requirements, and whether vouchers can be purchased in appropriate denominations, should be considered in determining availability. The final regulations adopt this suggestion because nonfinancial restrictions would reasonably affect whether vouchers are available for distribution by an employer to an employee.

The final regulations provide guidance on the types of nonfinancial restrictions that cause vouchers to not be readily available. The final regulations provide that certain nonfinancial restrictions, such as a voucher provider not making vouchers available for purchase at reasonable intervals or failing to provide the vouchers within a reasonable period after receiving payment for the voucher, cause vouchers to not be readily available. In addition, if a voucher provider does not provide vouchers in reasonably appropriate quantities, or in reasonably appropriate denominations, vouchers may not be readily available.

When and as the standards in these final regulations go into effect, they will supercede the current law standards in Notice 94–3.

B. Advance Transit Passes

Commentators suggested that the administrability of transit pass programs would be improved if vouchers were permitted to be distributed in advance for more than one month. The final regulations adopt this suggestion.

In October of this year, the IRS issued Announcement 2000–78 (2000–43 I.R.B. 428) to notify taxpayers that, when finalized, the regulations will clarify that transit passes may be distributed in advance for more than one month (such as for a calendar quarter) by taking into account the monthly limits for all months for which the transit passes are distributed. The announcement further provides, however, that if an employee receives advance transit passes, and the employee's employment terminates before the beginning of the last month of the period for which the transit passes were provided, the employer must include in the employee's wages, for income and for employment tax purposes (FICA, FUTA, and income tax withholding), the value of the passes provided for those month(s) beginning after the employee's employment terminates to the extent the employer does not recover those transit passes or the value of those passes. The announcement provides that pending the issuance of these final regulations, employers may rely on the announcement.

The final regulations differ from the announcement in one respect. In any case in which transit passes are provided in advance for a period of no more than three months (such as for a calendar quarter), but the recipient ceases to be an employee before the beginning of the last month in that period, the final regulations provide that the value of a transit pass provided in advance for a month is excluded from wages for employment tax (FICA, FUTA, and income tax withholding) purposes (but not for income tax purposes) unless at the time the transit passes were distributed there was an established termination date that was before the beginning of the last month of that period and the employee does in fact terminate employment before the beginning of the last month of that period.

C. Qualified Parking

The final regulations address whether reimbursement paid to an employee for parking at a work location away from the employee's permanent work location is excludable from wages for income and employment tax purposes under section 132(f). Section 132(f)(5)(C) defines qualified parking, in part, as ''parking provided to an employee on or near the business premises of the employer * * * .'' The final regulations provide that qualified parking includes parking on or near a work location at which the employee performs services for the employer. However, qualified parking does not include reimbursement for parking that is otherwise excludable from gross income as a reimbursement treated as paid under an accountable plan under § 1.62–2 of the Income Tax Regulations, or parking provided in kind to an employee that is excludable from the employee's gross income as a working condition fringe under section 132(a)(3). Thus, if the exclusion at § 1.62–2 or section 132(a)(3) is available (even if not reimbursed by the employer), then section 132(f) does not apply.

Whether a reimbursement for local transportation expenses, including parking at a work location away from the employee's permanent work location, is excludable from the employee's gross income under § 1.62–2, or whether parking provided in kind to an employee is excludable from the employee's gross income under section 132(a)(3), is determined based upon whether the parking expenses would be deductible if paid or incurred by the employee under section 162(a) as an expense incurred in the employee's trade or business of being an employee for the employer. §§ 1.62–2(d); 1.132–5(a)(2). Revenue Ruling 99–7 (1999–1 C.B. 361) addresses under what circumstances daily transportation expenses, including parking, incurred by a taxpayer in going between the taxpayer's residence and a work location are deductible by the taxpayer under section 162(a).

The final regulations provide the minimum requirements to ensure that transportation benefits are qualified transportation fringes under section 132(f). An employer may have a transit benefit program that is more restrictive than a program meeting the minimum requirements under the regulations. In addition, these regulations do not affect the application of authorities outside the Internal Revenue Code which may restrict a transportation benefit program. Federal Government agencies, for example, may be required by other federal law to implement restrictions beyond those required under these regulations.

D. Applicability Date

The regulations are generally applicable for taxable years beginning after December 31, 2001. However, in order to provide a transition period for those affected by the 1 percent rule (described under ''The 1 percent safe harbor'' in this preamble), that rule is applicable for taxable years beginning after December 31, 2003.

Effect on Other Documents

The following document is obsolete as of January 11, 2001: Announcement 2000–78 (2000–43 I.R.B. 428).

The following document is modified as of the date these regulations become applicable (see Q/A–25): Notice 94–3 (1994–1 C.B. 327).

Special Analyses

It has been determined that this Treasury Decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. A final regulatory flexibility analysis has been prepared for the collection of information in this Treasury decision under 5 U.S.C. 604. A summary of the analysis is set forth in this preamble under the heading ''Summary of Final Regulatory Flexibility Analysis.''

Summary of Final Regulatory Flexibility Analysis

This analysis is required under the Regulatory Flexibility Act (5 U.S.C. chapter 6). The collection of information under this rule is based upon the requirements under section 132(f). We estimate that approximately 265,000 employers that provide qualified transportation fringes to their employees will be affected by the recordkeeping requirements of this rule. None of the comments received in response to the notice of proposed rulemaking specifically addressed the initial regulatory flexibility analysis.

Section 132(f)(3) provides that qualified transportation fringes may be provided in the form of cash reimbursement. The legislative history indicates that an employer providing cash reimbursement to the employer's employees for qualified transportation fringes must establish a bona fide reimbursement arrangement. As a condition to providing cash reimbursement for qualified transportation fringes, this rule provides that employers must receive substantiation from employees. The objective of this rule is to ensure that reimbursements are made for qualified transportation fringes.

Whether an arrangement constitutes a bona fide reimbursement arrangement varies depending on the facts and circumstances, including the method or

methods of payment utilized within a mass transit system. An employee certification in either written or electronic form may be sufficient depending upon the facts and circumstances. For example, if receipts are not provided in the ordinary course of business, such as with respect to metered parking or used transit passes that cannot be returned to the user, an employee certification that expenses have been incurred constitutes a reasonable reimbursement procedure. A certification that expenses will be incurred in the future, by itself, is not a reasonable reimbursement procedure. There are no particular professional skills required to maintain these records.

In addition, section 132(f)(4) provides that an employee may choose between cash compensation and qualified transportation fringes. This rule provides that an employer may allow an employee the choice to receive either a fixed amount of cash compensation at a specified future date or a fixed amount of qualified transportation fringes to be provided for a specified future period (such as qualified parking to be used during a future calendar month). This rule provides that employers must keep records with respect to employee compensation reduction elections. An employee's election must be in writing or some other permanent and verifiable form, and include the date of the election, the amount of compensation to be reduced, and the period for which the qualified transportation fringes will be provided. The objective of this rule is to ensure against recharacterization of taxable compensation after it has been paid to the employee. There are no particular professional skills required to maintain these records.

A less burdensome alternative for small organizations would be to exempt those entities from the recordkeeping requirements under this rule. However, it would be inconsistent with the statutory provisions and legislative history to exempt those entities from the recordkeeping requirements imposed under this rule.

This rule provides several options which avoid more burdensome recordkeeping requirements for small entities. This rule provides that (1) there are no substantiation requirements if the employer distributes transit passes in kind; (2) a compensation reduction election may be made electronically; (3) an election to reduce compensation may be automatically renewed; (4) an employer may provide for deemed compensation reduction elections under its qualified transportation fringe benefit plan; and (5) a requirement that a voucher be distributed in-kind by the employer is satisfied if the voucher is distributed by the employer or by another person on behalf of the employer (for example, if a transit operator credits amounts to the employee's fare card as a result of payments made to the operator by the employer).

Drafting Information

The principal author of these regulations is John Richards, Office of the Assistant Chief Counsel (Exempt Organizations/Employment Tax/Government Entities). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Employment taxes, Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

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

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 1.132–0 is amended by:

1. Adding an entry for § 1.132–5(p)(4)
2. Adding entries for § 1.132–9.

The additions read as follows:

§ 1.132–0 Outline of regulations under section 132.

* * * * *

§ 1.132–5 Working condition fringes.

* * * * *

(p) * * *

(4) Dates of applicability.

* * * * *

§ 1.132–9 Qualified transportation fringes.

(a) Table of contents.

(b) Questions and answers.

Par. 3. Section 1.132–5 is amended by adding paragraph (p)(4) to read as follows:

§ 1.132–5 Working condition fringes.

* * * * *

(p) * * *

(4) *Dates of applicability.* This paragraph (p) applies to benefits provided before January 1, 1993. For benefits provided after December 31, 1992, see § 1.132–9.

* * * * *

Par. 4. Section 1.132–9 is added to read as follows:

§ 1.132–9 Qualified transportation fringes.

(a) *Table of contents.* This section contains a list of the questions and answers in § 1.132–9.

(1) *General rules.*

Q–1. What is a qualified transportation fringe?

Q–2. What is transportation in a commuter highway vehicle?

Q–3. What are transit passes?

Q–4. What is qualified parking?

Q–5. May qualified transportation fringes be provided to individuals who are not employees?

Q–6. Must a qualified transportation fringe benefit plan be in writing?

(2) *Dollar limitations.*

Q–7. Is there a limit on the value of qualified transportation fringes that may be excluded from an employee's gross income?

Q–8. What amount is includible in an employee's wages for income and employment tax purposes if the value of the qualified transportation fringe exceeds the applicable statutory monthly limit?

Q–9. Are excludable qualified transportation fringes calculated on a monthly basis?

Q–10. May an employee receive qualified transportation fringes from more than one employer?

(3) *Compensation reduction.*

Q–11. May qualified transportation fringes be provided to employees pursuant to a compensation reduction agreement?

Q–12. What is a compensation reduction election for purposes of section 132(f)?

Q–13. Is there a limit to the amount of the compensation reduction?

Q–14. When must the employee have made a compensation reduction election and under what circumstances may the amount be paid in cash to the employee?

Q–15. May an employee whose qualified transportation fringe costs are less than the employee's compensation reduction carry over this excess amount to subsequent periods?

(4) *Expense reimbursements.*

Q–16. How does section 132(f) apply to expense reimbursements?

Q–17. May an employer provide nontaxable cash reimbursement under section 132(f) for periods longer than one month?

Q–18. What are the substantiation requirements if an employer distributes transit passes?

Q–19. May an employer choose to impose substantiation requirements in addition to those described in this regulation?

(5) *Special rules for parking and vanpools.*

Q–20. How is the value of parking determined?

Q–21. How do the qualified transportation fringe rules apply to van pools?

(6) *Reporting and employment taxes.*

Q–22. What are the reporting and employment tax requirements for qualified transportation fringes?
(7) *Interaction with other fringe benefits.*
Q–23. How does section 132(f) interact with other fringe benefit rules?
(8) *Application to individuals who are not employees.*
Q–24. May qualified transportation fringes be provided to individuals who are partners, 2-percent shareholders of S-corporations, or independent contractors?
(9) *Effective date.*
Q–25. What is the effective date of this section?

(b) *Questions and answers.*

Q–1. What is a qualified transportation fringe?

A–1. (a) The following benefits are qualified transportation fringe benefits:

(1) Transportation in a commuter highway vehicle.

(2) Transit passes.

(3) Qualified parking.

(b) An employer may simultaneously provide an employee with any one or more of these three benefits.

Q–2. What is transportation in a commuter highway vehicle?

A–2. Transportation in a commuter highway vehicle is transportation provided by an employer to an employee in connection with travel between the employee's residence and place of employment. A commuter highway vehicle is a highway vehicle with a seating capacity of at least 6 adults (excluding the driver) and with respect to which at least 80 percent of the vehicle's mileage for a year is reasonably expected to be—

(a) For transporting employees in connection with travel between their residences and their place of employment; and

(b) On trips during which the number of employees transported for commuting is at least one-half of the adult seating capacity of the vehicle (excluding the driver).

Q–3. What are transit passes?

A–3. A transit pass is any pass, token, farecard, voucher, or similar item (including an item exchangeable for fare media) that entitles a person to transportation—

(a) On mass transit facilities (whether or not publicly owned); or

(b) Provided by any person in the business of transporting persons for compensation or hire in a highway vehicle with a seating capacity of at least 6 adults (excluding the driver).

Q–4. What is qualified parking?

A–4. (a) Qualified parking is parking provided to an employee by an employer—

(1) On or near the employer's business premises; or

(2) At a location from which the employee commutes to work (including commuting by carpool, commuter highway vehicle, mass transit facilities, or transportation provided by any person in the business of transporting persons for compensation or hire).

(b) For purposes of section 132(f), parking on or near the employer's business premises includes parking on or near a work location at which the employee provides services for the employer. However, qualified parking does not include—

(1) The value of parking provided to an employee that is excludable from gross income under section 132(a)(3) (as a working condition fringe), or

(2) Reimbursement paid to an employee for parking costs that is excludable from gross income as an amount treated as paid under an accountable plan. See § 1.62–2.

(c) However, parking on or near property used by the employee for residential purposes is not qualified parking.

(d) Parking is provided by an employer if—

(1) The parking is on property that the employer owns or leases;

(2) The employer pays for the parking; or

(3) The employer reimburses the employee for parking expenses (see Q/A–16 of this section for rules relating to cash reimbursements).

Q–5. May qualified transportation fringes be provided to individuals who are not employees?

A–5. An employer may provide qualified transportation fringes only to individuals who are currently employees of the employer at the time the qualified transportation fringe is provided. The term employee for purposes of qualified transportation fringes is defined in § 1.132–1(b)(2)(i). This term includes only common law employees and other statutory employees, such as officers of corporations. See Q/A–24 of this section for rules regarding partners, 2-percent shareholders, and independent contractors.

Q–6. Must a qualified transportation fringe benefit plan be in writing?

A–6. No. Section 132(f) does not require that a qualified transportation fringe benefit plan be in writing.

Q–7. Is there a limit on the value of qualified transportation fringes that may be excluded from an employee's gross income?

A–7. (a) *Transportation in a commuter highway vehicle and transit passes.* Before January 1, 2002, up to $65 per month is excludable from the gross income of an employee for transportation in a commuter highway vehicle and transit passes provided by an employer. On January 1, 2002, this amount is increased to $100 per month.

(b) *Parking.* Up to $175 per month is excludable from the gross income of an employee for qualified parking.

(c) *Combination.* An employer may provide qualified parking benefits in addition to transportation in a commuter highway vehicle and transit passes.

(d) *Cost-of-living adjustments.* The amounts in paragraphs (a) and (b) of this Q/A–7 are adjusted annually, beginning with 2000, to reflect cost-of-living. The adjusted figures are announced by the Service before the beginning of the year.

Q–8. What amount is includible in an employee's wages for income and employment tax purposes if the value of the qualified transportation fringe exceeds the applicable statutory monthly limit?

A–8. (a) Generally, an employee must include in gross income the amount by which the fair market value of the benefit exceeds the sum of the amount, if any, paid by the employee and any amount excluded from gross income under section 132(a)(5). Thus, assuming no other statutory exclusion applies, if an employer provides an employee with a qualified transportation fringe that exceeds the applicable statutory monthly limit and the employee does not make any payment, the value of the benefits provided in excess of the applicable statutory monthly limit is included in the employee's wages for income and employment tax purposes. See § 1.61–21(b)(1).

(b) The following examples illustrate the principles of this Q/A–8:

Example 1. (i) For each month in a year in which the statutory monthly transit pass limit is $100 (i.e., a year after 2001), Employer M provides a transit pass valued at $110 to Employee D, who does not pay any amount to Employer M for the transit pass.

(ii) In this *Example 1,* because the value of the monthly transit pass exceeds the statutory monthly limit by $10, $120 ($110—$100, times 12 months) must be included in D's wages for income and employment tax purposes for the year with respect to the transit passes.

Example 2. (i) For each month in a year in which the statutory monthly qualified parking limit is $175, Employer M provides qualified parking valued at $195 to Employee E, who does not pay any amount to M for the parking.

(ii) In this *Example 2,* because the fair market value of the qualified parking exceeds the statutory monthly limit by $20, $240 ($195—$175, times 12 months) must be included in Employee E's wages for income and employment tax purposes for the year with respect to the qualified parking.

Example 3. (i) For each month in a year in which the statutory monthly qualified parking limit is $175, Employer P provides

qualified parking with a fair market value of $220 per month to its employees, but charges each employee $45 per month.

(ii) In this *Example 3,* because the sum of the amount paid by an employee ($45) plus the amount excludable for qualified parking ($175) is not less than the fair market value of the monthly benefit, no amount is includible in the employee's wages for income and employment tax purposes with respect to the qualified parking.

Q–9. Are excludable qualified transportation fringes calculated on a monthly basis?

A–9. (a) *In general.* Yes. The value of transportation in a commuter highway vehicle, transit passes, and qualified parking is calculated on a monthly basis to determine whether the value of the benefit has exceeded the applicable statutory monthly limit on qualified transportation fringes. Except in the case of a transit pass provided to an employee, the applicable statutory monthly limit applies to qualified transportation fringes used by the employee in a month. Monthly exclusion amounts are not combined to provide a qualified transportation fringe for any month exceeding the statutory limit. A month is a calendar month or a substantially equivalent period applied consistently.

(b) *Transit passes.* In the case of transit passes provided to an employee, the applicable statutory monthly limit applies to the transit passes provided by the employer to the employee in a month for that month or for any previous month in the calendar year. In addition, transit passes distributed in advance for more than one month, but not for more than twelve months, are qualified transportation fringes if the requirements in paragraph (c) of this Q/A–9 are met (relating to the income tax and employment tax treatment of advance transit passes). The applicable statutory monthly limit under section 132(f)(2) on the combined amount of transportation in a commuter highway vehicle and transit passes may be calculated by taking into account the monthly limits for all months for which the transit passes are distributed. In the case of a pass that is valid for more than one month, such as an annual pass, the value of the pass may be divided by the number of months for which it is valid for purposes of determining whether the value of the pass exceeds the statutory monthly limit.

(c) *Rule if employee's employment terminates*—(1) *Income tax treatment.* The value of transit passes provided in advance to an employee with respect to a month in which the individual is not an employee is included in the employee's wages for income tax purposes.

(2) *Reporting and employment tax treatment.* Transit passes distributed in advance to an employee are excludable from wages for employment tax purposes under sections 3121, 3306, and 3401 (FICA, FUTA, and income tax withholding) if the employer distributes transit passes to the employee in advance for not more than three months and, at the time the transit passes are distributed, there is not an established date that the employee's employment will terminate (for example, if the employee has given notice of retirement) which will occur before the beginning of the last month of the period for which the transit passes are provided. If the employer distributes transit passes to an employee in advance for not more than three months and at the time the transit passes are distributed there is an established date that the employee's employment will terminate, and the employee's employment does terminate before the beginning of the last month of the period for which the transit passes are provided, the value of transit passes provided for months beginning after the date of termination during which the employee is not employed by the employer is included in the employee's wages for employment tax purposes. If transit passes are distributed in advance for more than three months, the value of transit passes provided for the months during which the employee is not employed by the employer is includible in the employee's wages for employment tax purposes regardless of whether at the time the transit passes were distributed there was an established date of termination of the employee's employment.

(d) *Examples.* The following examples illustrate the principles of this Q/A–9:

Example 1. (i) Employee E incurs $150 for qualified parking used during the month of June of a year in which the statutory monthly parking limit is $175, for which E is reimbursed $150 by Employer R. Employee E incurs $180 in expenses for qualified parking used during the month of July of that year, for which E is reimbursed $180 by Employer R.

(ii) In this *Example 1,* because monthly exclusion amounts may not be combined to provide a benefit in any month greater than the applicable statutory limit, the amount by which the amount reimbursed for July exceeds the applicable statutory monthly limit ($180 minus $175 equals $5) is includible in Employee E's wages for income and employment tax purposes.

Example 2. (i) Employee F receives transit passes from Employer G with a value of $195 in March of a year (for which the statutory monthly transit pass limit is $65) for January, February, and March of that year. F was hired during January and has not received any transit passes from G.

(ii) In this *Example 2,* the value of the transit passes (three months times $65 equals $195) is excludable from F's wages for income and employment tax purposes.

Example 3. (i) Employer S has a qualified transportation fringe benefit plan under which its employees receive transit passes near the beginning of each calendar quarter for that calendar quarter. All employees of Employer S receive transit passes from Employer S with a value of $195 on March 31 for the second calendar quarter covering the months April, May, and June (of a year in which the statutory monthly transit pass limit is $65).

(ii) In this *Example 3,* because the value of the transit passes may be calculated by taking into account the monthly limits for all months for which the transit passes are distributed, the value of the transit passes (three months times $65 equals $195) is excludable from the employees' wages for income and employment tax purposes.

Example 4. (i) Same facts as in *Example 3,* except that Employee T, an employee of Employer S, terminates employment with S on May 31. There was not an established date of termination for Employee T at the time the transit passes were distributed.

(ii) In this *Example 4,* because at the time the transit passes were distributed there was not an established date of termination for Employee T, the value of the transit passes provided for June ($65) is excludable from T's wages for employment tax purposes. However, the value of the transit passes distributed to Employee T for June ($65) is not excludable from T's wages for income tax purposes.

(iii) If Employee T's May 31 termination date was established at the time the transit passes were provided, the value of the transit passes provided for June ($65) is included in T's wages for both income and employment tax purposes.

Example 5. (i) Employer F has a qualified transportation fringe benefit plan under which its employees receive transit passes semi-annually in advance of the months for which the transit passes are provided. All employees of Employer F, including Employee X, receive transit passes from F with a value of $390 on June 30 for the 6 months of July through December (of a year in which the statutory monthly transit pass limit is $65). Employee X's employment terminates and his last day of work is August 1. Employer F's other employees remain employed throughout the remainder of the year.

(ii) In this *Example 5,* the value of the transit passes provided to Employee X for the months September, October, November, and December ($65 times 4 months equals $260) of the year is included in X's wages for income and employment tax purposes. The value of the transit passes provided to Employer F's other employees is excludable from the employees' wages for income and employment tax purposes.

Example 6. (i) Each month during a year in which the statutory monthly transit pass limit is $65, Employer R distributes transit

passes with a face amount of $70 to each of its employees. Transit passes with a face amount of $70 can be purchased from the transit system by any individual for $65.

(ii) In this *Example 6,* because the value of the transit passes distributed by Employer R does not exceed the applicable statutory monthly limit ($65), no portion of the value of the transit passes is included as wages for income and employment tax purposes.

Q–10. May an employee receive qualified transportation fringes from more than one employer?

A–10. (a) *General rule.* Yes. The statutory monthly limits described in Q/A–7 of this section apply to benefits provided by an employer to its employees. For this purpose, all employees treated as employed by a single employer under section 414(b), (c), (m), or (o) are treated as employed by a single employer. See section 414(t) and § 1.132–1(c). Thus, qualified transportation fringes paid by entities under common control under section 414(b), (c), (m), or (o) are combined for purposes of applying the applicable statutory monthly limit. In addition, an individual who is treated as a leased employee of the employer under section 414(n) is treated as an employee of that employer for purposes of section 132. See section 414(n)(3)(C).

(b) *Examples.* The following examples illustrate the principles of this Q/A–10:

Example 1. (i) During a year in which the statutory monthly qualified parking limit is $175, Employee E works for Employers M and N, who are unrelated and not treated as a single employer under section 414(b), (c), (m), or (o). Each month, M and N each provide qualified parking benefits to E with a value of $100.

(ii) In this *Example 1,* because M and N are unrelated employers, and the value of the monthly parking benefit provided by each is not more than the applicable statutory monthly limit, the parking benefits provided by each employer are excludable as qualified transportation fringes assuming that the other requirements of this section are satisfied.

Example 2. (i) Same facts as in Example 1, except that Employers M and N are treated as a single employer under section 414(b).

(ii) In this *Example 2,* because M and N are treated as a single employer, the value of the monthly parking benefit provided by M and N must be combined for purposes of determining whether the applicable statutory monthly limit has been exceeded. Thus, the amount by which the value of the parking benefit exceeds the monthly limit ($200 minus the monthly limit amount of $175 equals $25) for each month in the year is includible in E's wages for income and employment tax purposes.

Q–11. May qualified transportation fringes be provided to employees pursuant to a compensation reduction agreement?

A–11. Yes. An employer may offer employees a choice between cash compensation and any qualified transportation fringe. An employee who is offered this choice and who elects qualified transportation fringes is not required to include the cash compensation in income if—

(a) The election is pursuant to an arrangement described in Q/A–12 of this section;

(b) The amount of the reduction in cash compensation does not exceed the limitation in Q/A–13 of this section;

(c) The arrangement satisfies the timing and reimbursement rules in Q/A–14 and 16 of this section; and

(d) The related fringe benefit arrangement otherwise satisfies the requirements set forth elsewhere in this section.

Q–12. What is a compensation reduction election for purposes of section 132(f)?

A–12. (a) *Election requirements generally.* A compensation reduction arrangement is an arrangement under which the employer provides the employee with the right to elect whether the employee will receive either a fixed amount of cash compensation at a specified future date or a fixed amount of qualified transportation fringes to be provided for a specified future period (such as qualified parking to be used during a future calendar month). The employee's election must be in writing or another form, such as electronic, that includes, in a permanent and verifiable form, the information required to be in the election. The election must contain the date of the election, the amount of the compensation to be reduced, and the period for which the benefit will be provided. The election must relate to a fixed dollar amount or fixed percentage of compensation reduction. An election to reduce compensation for a period by a set amount for such period may be automatically renewed for subsequent periods.

(b) *Automatic election permitted.* An employer may provide under its qualified transportation fringe benefit plan that a compensation reduction election will be deemed to have been made if the employee does not elect to receive cash compensation in lieu of the qualified transportation fringe, provided that the employee receives adequate notice that a compensation reduction will be made and is given adequate opportunity to choose to receive the cash compensation instead of the qualified transportation fringe.

Q–13. Is there a limit to the amount of the compensation reduction?

A–13. Yes. Each month, the amount of the compensation reduction may not exceed the combined applicable statutory monthly limits for transportation in a commuter highway vehicle, transit passes, and qualified parking. For example, for a year in which the statutory monthly limit is $65 for transportation in a commuter highway vehicle and transit passes, and $175 for qualified parking, an employee could elect to reduce compensation for any month by no more than $240 ($65 plus $175) with respect to qualified transportation fringes. If an employee were to elect to reduce compensation by $250 for a month, the excess $10 ($250 minus $240) would be includible in the employee's wages for income and employment tax purposes.

Q–14. When must the employee have made a compensation reduction election and under what circumstances may the amount be paid in cash to the employee?

A–14. (a) The compensation reduction election must satisfy the requirements set forth under paragraphs (b), (c), and (d) of this Q/A–14.

(b) *Timing of election.* The compensation reduction election must be made before the employee is able currently to receive the cash or other taxable amount at the employee's discretion. The determination of whether the employee is able currently to receive the cash does not depend on whether it has been constructively received for purposes of section 451. The election must specify that the period (such as a calendar month) for which the qualified transportation fringe will be provided must not begin before the election is made. Thus, a compensation reduction election must relate to qualified transportation fringes to be provided after the election. For this purpose, the date a qualified transportation fringe is provided is—

(1) The date the employee receives a voucher or similar item; or

(2) In any other case, the date the employee uses the qualified transportation fringe.

(c) *Revocability of elections.* The employee may not revoke a compensation reduction election after the employee is able currently to receive the cash or other taxable amount at the employee's discretion. In addition, the election may not be revoked after the beginning of the period for which the qualified transportation fringe will be provided.

(d) *Compensation reduction amounts not refundable.* Unless an election is revoked in a manner consistent with paragraph (c) of this Q/A–14, an employee may not subsequently receive the compensation (in cash or any form other than by payment of a qualified transportation fringe under the employer's plan). Thus, an employer's

qualified transportation fringe benefit plan may not provide that an employee who ceases to participate in the employer's qualified transportation fringe benefit plan (such as in the case of termination of employment) is entitled to receive a refund of the amount by which the employee's compensation reductions exceed the actual qualified transportation fringes provided to the employee by the employer.

(e) *Examples.* The following examples illustrate the principles of this Q/A–14:

Example 1. (i) Employer P maintains a qualified transportation fringe benefit arrangement during a year in which the statutory monthly limit is $100 for transportation in a commuter highway vehicle and transit passes (2002 or later) and $180 for qualified parking. Employees of P are paid cash compensation twice per month, with the payroll dates being the first and the fifteenth day of the month. Under P's arrangement, an employee is permitted to elect at any time before the first day of a month to reduce his or her compensation payable during that month in an amount up to the applicable statutory monthly limit ($100 if the employee elects coverage for transportation in a commuter highway vehicle or a mass transit pass, or $180 if the employee chooses qualified parking) in return for the right to receive qualified transportation fringes up to the amount of the election. If such an election is made, P will provide a mass transit pass for that month with a value not exceeding the compensation reduction amount elected by the employee or will reimburse the cost of other qualified transportation fringes used by the employee on or after the first day of that month up to the compensation reduction amount elected by the employee. Any compensation reduction amount elected by the employee for the month that is not used for qualified transportation fringes is not refunded to the employee at any future date.

(ii) In this *Example 1*, the arrangement satisfies the requirements of this Q/A–14 because the election is made before the employee is able currently to receive the cash and the election specifies the future period for which the qualified transportation fringes will be provided. The arrangement would also satisfy the requirements of this Q/A–14 and Q/A–13 of this section if employees are allowed to elect to reduce compensation up to $280 per month ($100 plus $180).

(iii) The arrangement would also satisfy the requirements of this Q/A–14 (and Q/A–13 of this section) if employees are allowed to make an election at any time before the first or the fifteenth day of the month to reduce their compensation payable on that payroll date by an amount not in excess of one-half of the applicable statutory monthly limit (depending on the type of qualified transportation fringe elected by the employee) and P provides a mass transit pass on or after the applicable payroll date for the compensation reduction amount elected by the employee for the payroll date or reimburses the cost of other qualified transportation fringes used by the employee on or after the payroll date up to the compensation reduction amount elected by the employee for that payroll date.

Example 2. (i) Employee Q elects to reduce his compensation payable on March 1 of a year (for which the statutory monthly mass transit limit is $65) by $195 in exchange for a mass transit voucher to be provided in March. The election is made on the preceding February 27. Employee Q was hired in January of the year. On March 10 of the year, the employer of Employee Q delivers to Employee Q a mass transit voucher worth $195 for the months of January, February, and March.

(ii) In this *Example 2*, $65 is included in Employee Q's wages for income and employment tax purposes because the compensation reduction election fails to satisfy the requirement in this Q/A–14 and Q/A–12 of this section that the period for which the qualified transportation fringe will be provided not begin before the election is made to the extent the election relates to $65 worth of transit passes for January of the year. The $65 for February is not taxable because the election was for a future period that includes at least one day in February.

(iii) However, no amount would be included in Employee Q's wages as a result of the election if $195 worth of mass transit passes were instead provided to Q for the months of February, March, and April (because the compensation reduction would relate solely to fringes to be provided for a period not beginning before the date of the election and the amount provided does not exceed the aggregate limit for the period, *i.e.,* the sum of $65 for each of February, March, and April). See Q/A–9 of this section for rules governing transit passes distributed in advance for more than one month.

Example 3. (i) Employee R elects to reduce his compensation payable on March 1 of a year (for which the statutory monthly parking limit is $175) by $185 in exchange for reimbursement by Employer T of parking expenses incurred by Employee R for parking on or near Employer T's business premises during the period beginning after the date of the election through March. The election is made on the preceding February 27. Employee R incurs $10 in parking expenses on February 28 of the year, and $175 in parking expenses during the month of March. On April 5 of the year, Employer T reimburses Employee R $185 for the parking expenses incurred on February 28, and during March, of the year.

(ii) In this *Example 3*, no amount would be includible in Employee R's wages for income and employment tax purposes because the compensation reduction related solely to parking on or near Employer R's business premises used during a period not beginning before the date of the election and the amount reimbursed for parking used in any one month does not exceed the statutory monthly limitation.

Q–15. May an employee whose qualified transportation fringe costs are less than the employee's compensation reduction carry over this excess amount to subsequent periods?

A–15. (a) Yes. An employee may carry over unused compensation reduction amounts to subsequent periods under the plan of the employee's employer.

(b) The following example illustrates the principles of this Q/A–15:

Example. (i) By an election made before November 1 of a year for which the statutory monthly mass transit limit is $65, Employee E elects to reduce compensation in the amount of $65 for the month of November. E incurs $50 in employee-operated commuter highway vehicle expenses during November for which E is reimbursed $50 by Employer R, E's employer. By an election made before December, E elects to reduce compensation by $65 for the month of December. E incurs $65 in employee-operated commuter highway vehicle expenses during December for which E is reimbursed $65 by R. Before the following January, E elects to reduce compensation by $50 for the month of January. E incurs $65 in employee-operated commuter highway vehicle expenses during January for which E is reimbursed $65 by R because R allows E to carry over to the next year the $15 amount by which the compensation reductions for November and December exceeded the employee-operated commuter highway vehicle expenses incurred during those months.

(ii) In this *Example*, because Employee E is reimbursed in an amount not exceeding the applicable statutory monthly limit, and the reimbursement does not exceed the amount of employee-operated commuter highway vehicle expenses incurred during the month of January, the amount reimbursed ($65) is excludable from E's wages for income and employment tax purposes.

Q–16. How does section 132(f) apply to expense reimbursements?

A–16. (a) *In general.* The term qualified transportation fringe includes cash reimbursement by an employer to an employee for expenses incurred or paid by an employee for transportation in a commuter highway vehicle or qualified parking. The term qualified transportation fringe also includes cash reimbursement for transit passes made under a bona fide reimbursement arrangement, but, in accordance with section 132(f)(3), only if permitted under paragraph (b) of this Q/A–16. The reimbursement must be made under a bona fide reimbursement arrangement which meets the rules of paragraph (c) of this Q/A–16. A payment made before the date an expense has been incurred or paid is not a reimbursement. In addition, a bona fide reimbursement arrangement does not include an arrangement that is dependent solely upon an employee certifying in advance that the employee will incur expenses at some future date.

(b) *Special rule for transit passes*—(1) *In general.* The term *qualified transportation fringe* includes cash reimbursement for transit passes made

under a bona fide reimbursement arrangement, but, in accordance with section 132(f)(3), only if no voucher or similar item that may be exchanged only for a transit pass is readily available for direct distribution by the employer to employees. If a voucher is readily available, the requirement that a voucher be distributed in-kind by the employer is satisfied if the voucher is distributed by the employer or by another person on behalf of the employer (for example, if a transit operator credits amounts to the employee's fare card as a result of payments made to the operator by the employer).

(2) *Voucher or similar item.* For purposes of the special rule in paragraph (b) of this Q/A–16, a transit system voucher is an instrument that may be purchased by employers from a voucher provider that is accepted by one or more mass transit operators (*e.g.,* train, subway, and bus) in an area as fare media or in exchange for fare media. Thus, for example, a transit pass that may be purchased by employers directly from a voucher provider is a transit system voucher.

(3) *Voucher provider.* The term voucher provider means any person in the trade or business of selling transit system vouchers to employers, or any transit system or transit operator that sells vouchers to employers for the purpose of direct distribution to employees. Thus, a transit operator might or might not be a voucher provider. A voucher provider is not, for example, a third-party employee benefits administrator that administers a transit pass benefit program for an employer using vouchers that the employer could obtain directly.

(4) *Readily available.* For purposes of this paragraph (b), a voucher or similar item is readily available for direct distribution by the employer to employees if and only if an employer can obtain it from a voucher provider that—

(i) does not impose fare media charges that cause vouchers to not be readily available as described in paragraph (b)(5) of this section; and

(ii) does not impose other restrictions that cause vouchers to not be readily available as described in paragraph (b)(6) of this section.

(5) *Fare media charges.* For purposes of paragraph (b)(4) of this section, fare media charges relate only to fees paid by the employer to voucher providers for vouchers. The determination of whether obtaining a voucher would result in fare media charges that cause vouchers to not be readily available as described in this paragraph (b) is made with respect to each transit system voucher. If more than one transit system voucher is available for direct distribution to employees, the employer must consider the fees imposed for the lowest cost monthly voucher for purposes of determining whether the fees imposed by the voucher provider satisfy this paragraph. However, if transit system vouchers for multiple transit systems are required in an area to meet the transit needs of the individual employees in that area, the employer has the option of averaging the costs applied to each transit system voucher for purposes of determining whether the fare media charges for transit system vouchers satisfy this paragraph. Fare media charges are described in this paragraph (b)(5), and therefore cause vouchers to not be readily available, if and only if the average annual fare media charges that the employer reasonably expects to incur for transit system vouchers purchased from the voucher provider (disregarding reasonable and customary delivery charges imposed by the voucher provider, *e.g.,* not in excess of $15) are more than 1 percent of the average annual value of the vouchers for a transit system.

(6) *Other restrictions.* For purposes of paragraph (b)(4) of this section, restrictions that cause vouchers to not be readily available are restrictions imposed by the voucher provider other than fare media charges that effectively prevent the employer from obtaining vouchers appropriate for distribution to employees. Examples of such restrictions include—

(i) *Advance purchase requirements.* Advance purchase requirements cause vouchers to not be readily available only if the voucher provider does not offer vouchers at regular intervals or fails to provide the voucher within a reasonable period after receiving payment for the voucher. For example, a requirement that vouchers may be purchased only once per year may effectively prevent an employer from obtaining vouchers for distribution to employees. An advance purchase requirement that vouchers be purchased not more frequently than monthly does not effectively prevent the employer from obtaining vouchers for distribution to employees.

(ii) *Purchase quantity requirements.* Purchase quantity requirements cause vouchers to not be readily available if the voucher provider does not offer vouchers in quantities that are reasonably appropriate to the number of the employer's employees who use mass transportation (for example, the voucher provider requires a $1,000 minimum purchase and the employer seeks to purchase only $200 of vouchers).

(iii) *Limitations on denominations of vouchers that are available.* If the voucher provider does not offer vouchers in denominations appropriate for distribution to the employer's employees, vouchers are not readily available. For example, vouchers provided in $5 increments up to the monthly limit are appropriate for distribution to employees, while vouchers available only in a denomination equal to the monthly limit are not appropriate for distribution to employees if the amount of the benefit provided to the employer's employees each month is normally less than the monthly limit.

(7) *Example.* The following example illustrates the principles of this paragraph (b):

Example. (i) Company C in City X sells mass transit vouchers to employers in the metropolitan area of X in various denominations appropriate for distribution to employees. Employers can purchase vouchers monthly in reasonably appropriate quantities. Several different bus, rail, van pool, and ferry operators service X, and a number of the operators accept the vouchers either as fare media or in exchange for fare media. To cover its operating expenses, C imposes on each voucher a 50 cents charge, plus a reasonable and customary $15 charge for delivery of each order of vouchers. Employer M disburses vouchers purchased from C to its employees who use operators that accept the vouchers and M reasonably expects that $55 is the average value of the voucher it will purchase from C for the next calendar year.

(ii) In this *Example*, vouchers for X are readily available for direct distribution by the employer to employees because the expected cost of the vouchers disbursed to M's employees for the next calendar year is not more than 1 percent of the value of the vouchers (50 cents divided by $55 equals 0.91 percent), the delivery charges are disregarded because they are reasonable and customary, and there are no other restrictions that cause the vouchers to not be readily available. Thus, any reimbursement of mass transportation costs in X would not be a qualified transportation fringe.

(c) *Substantiation requirements.* Employers that make cash reimbursements must establish a bona fide reimbursement arrangement to establish that their employees have, in fact, incurred expenses for transportation in a commuter highway vehicle, transit passes, or qualified parking. For purposes of section 132(f), whether cash reimbursements are made under a bona fide reimbursement arrangement may vary depending on the facts and circumstances, including the method or methods of payment utilized within the mass transit system. The

employer must implement reasonable procedures to ensure that an amount equal to the reimbursement was incurred for transportation in a commuter highway vehicle, transit passes, or qualified parking. The expense must be substantiated within a reasonable period of time. An expense substantiated to the payor within 180 days after it has been paid will be treated as having been substantiated within a reasonable period of time. An employee certification at the time of reimbursement in either written or electronic form may be a reasonable reimbursement procedure depending on the facts and circumstances. Examples of reasonable reimbursement procedures are set forth in paragraph (d) of this Q/A–16.

(d) *Illustrations of reasonable reimbursement procedures.* The following are examples of reasonable reimbursement procedures for purposes of paragraph (c) of this Q/A–16. In each case, the reimbursement is made at or within a reasonable period after the end of the events described in paragraphs (d)(1) through (d)(3) of this section.

(1) An employee presents to the employer a parking expense receipt for parking on or near the employer's business premises, the employee certifies that the parking was used by the employee, and the employer has no reason to doubt the employee's certification.

(2) An employee either submits a used time-sensitive transit pass (such as a monthly pass) to the employer and certifies that he or she purchased it or presents an unused or used transit pass to the employer and certifies that he or she purchased it and the employee certifies that he or she has not previously been reimbursed for the transit pass. In both cases, the employer has no reason to doubt the employee's certification.

(3) If a receipt is not provided in the ordinary course of business (*e.g.,* if the employee uses metered parking or if used transit passes cannot be returned to the user), the employee certifies to the employer the type and the amount of expenses incurred, and the employer has no reason to doubt the employee's certification.

Q–17. May an employer provide nontaxable cash reimbursement under section 132(f) for periods longer than one month?

A–17. (a) *General rule.* Yes. Qualified transportation fringes include reimbursement to employees for costs incurred for transportation in more than one month, provided the reimbursement for each month in the period is calculated separately and does not exceed the applicable statutory monthly limit for any month in the period. See Q/A–8 and 9 of this section if the limit for a month is exceeded.

(b) *Example.* The following example illustrates the principles of this Q/A–17:

Example. (i) Employee R pays $100 per month for qualified parking used during the period from April 1 through June 30 of a year in which the statutory monthly qualified parking limit is $175. After receiving adequate substantiation from Employee R, R's employer reimburses R $300 in cash on June 30 of that year.

(ii) In this *Example*, because the value of the reimbursed expenses for each month did not exceed the applicable statutory monthly limit, the $300 reimbursement is excludable from R's wages for income and employment tax purposes as a qualified transportation fringe.

Q–18. What are the substantiation requirements if an employer distributes transit passes?

A–18. There are no substantiation requirements if the employer distributes transit passes. Thus, an employer may distribute a transit pass for each month with a value not more than the statutory monthly limit without requiring any certification from the employee regarding the use of the transit pass.

Q–19. May an employer choose to impose substantiation requirements in addition to those described in this regulation?

A–19. Yes.

Q–20. How is the value of parking determined?

A–20. Section 1.61–21(b)(2) applies for purposes of determining the value of parking.

Q–21. How do the qualified transportation fringe rules apply to van pools?

A–21. (a) *Van pools generally.* Employer and employee-operated van pools, as well as private or public transit-operated van pools, may qualify as qualified transportation fringes. The value of van pool benefits which are qualified transportation fringes may be excluded up to the applicable statutory monthly limit for transportation in a commuter highway vehicle and transit passes, less the value of any transit passes provided by the employer for the month.

(b) *Employer-operated van pools.* The value of van pool transportation provided by or for an employer to its employees is excludable as a qualified transportation fringe, provided the van qualifies as a commuter highway vehicle as defined in section 132(f)(5)(B) and Q/A–2 of this section. A van pool is operated by or for the employer if the employer purchases or leases vans to enable employees to commute together or the employer contracts with and pays a third party to provide the vans and some or all of the costs of operating the vans, including maintenance, liability insurance and other operating expenses.

(c) *Employee-operated van pools.* Cash reimbursement by an employer to employees for expenses incurred for transportation in a van pool operated by employees independent of their employer are excludable as qualified transportation fringes, provided that the van qualifies as a commuter highway vehicle as defined in section 132(f)(5)(B) and Q/A–2 of this section. See Q/A–16 of this section for the rules governing cash reimbursements.

(d) *Private or public transit-operated van pool transit passes.* The qualified transportation fringe exclusion for transit passes is available for travel in van pools owned and operated either by public transit authorities or by any person in the business of transporting persons for compensation or hire. In accordance with paragraph (b) of Q/A–3 of this section, the van must seat at least 6 adults (excluding the driver). See Q/A–16(b) and (c) of this section for a special rule for cash reimbursement for transit passes and the substantiation requirements for cash reimbursement.

(e) *Value of van pool transportation benefits.* Section 1.61–21(b)(2) provides that the fair market value of a fringe benefit is based on all the facts and circumstances. Alternatively, transportation in an employer-provided commuter highway vehicle may be valued under the automobile lease valuation rule in § 1.61–21(d), the vehicle cents-per-mile rule in § 1.61–21(e), or the commuting valuation rule in § 1.61–21(f). If one of these special valuation rules is used, the employer must use the same valuation rule to value the use of the commuter highway vehicle by each employee who share the use. See § 1.61–21(c)(2)(i)(B).

(f) *Qualified parking prime member.* If an employee obtains a qualified parking space as a result of membership in a car or van pool, the applicable statutory monthly limit for qualified parking applies to the individual to whom the parking space is assigned. This individual is the prime member. In determining the tax consequences to the prime member, the statutory monthly limit amounts of each car pool member may not be combined. If the employer provides access to the space and the space is not assigned to a particular individual, then the employer must designate one of its employees as the prime member who will bear the tax consequences. The employer may not designate more than one prime member for a car or van pool during a month.

The employer of the prime member is responsible for including the value of the qualified parking in excess of the statutory monthly limit in the prime member's wages for income and employment tax purposes.

Q–22. What are the reporting and employment tax requirements for qualified transportation fringes?

A–22. (a) *Employment tax treatment generally.* Qualified transportation fringes not exceeding the applicable statutory monthly limit described in Q/A–7 of this section are not wages for purposes of the Federal Insurance Contributions Act (FICA), the Federal Unemployment Tax Act (FUTA), and federal income tax withholding. Any amount by which an employee elects to reduce compensation as provided in Q/A–11 of this section is not subject to the FICA, the FUTA, and federal income tax withholding. Qualified transportation fringes exceeding the applicable statutory monthly limit described in Q/A–7 of this section are wages for purposes of the FICA, the FUTA, and federal income tax withholding and are reported on the employee's Form W–2, Wage and Tax Statement.

(b) *Employment tax treatment of cash reimbursement exceeding monthly limits.* Cash reimbursement to employees (for example, cash reimbursement for qualified parking) in excess of the applicable statutory monthly limit under section 132(f) is treated as paid for employment tax purposes when actually or constructively paid. See §§ 31.3121(a)–2(a), 31.3301–4, 31.3402(a)–1(b) of this chapter. Employers must report and deposit the amounts withheld in addition to reporting and depositing other employment taxes. See Q/A–16 of this section for rules governing cash reimbursements.

(c) *Noncash fringe benefits exceeding monthly limits.* If the value of noncash qualified transportation fringes exceeds the applicable statutory monthly limit, the employer may elect, for purposes of the FICA, the FUTA, and federal income tax withholding, to treat the noncash taxable fringe benefits as paid on a pay period, quarterly, semi-annual, annual, or other basis, provided that the benefits are treated as paid no less frequently than annually.

Q–23. How does section 132(f) interact with other fringe benefit rules?

A–23. For purposes of section 132, the terms working condition fringe and de minimis fringe do not include any qualified transportation fringe under section 132(f). If, however, an employer provides local transportation other than transit passes (without any direct or indirect compensation reduction election), the value of the benefit may be excludable, either totally or partially, under fringe benefit rules other than the qualified transportation fringe rules under section 132(f). See §§ 1.132–6(d)(2)(i) (occasional local transportation fare), 1.132–6(d)(2)(iii) (transportation provided under unusual circumstances), and 1.61–21(k) (valuation of local transportation provided to qualified employees). See also Q/A–4(b) of this section.

Q–24. May qualified transportation fringes be provided to individuals who are partners, 2-percent shareholders of S-corporations, or independent contractors?

A–24. (a) *General rule.* Section 132(f)(5)(E) states that self-employed individuals who are employees within the meaning of section 401(c)(1) are not employees for purposes of section 132(f). Therefore, individuals who are partners, sole proprietors, or other independent contractors are not employees for purposes of section 132(f). In addition, under section 1372(a), 2-percent shareholders of S corporations are treated as partners for fringe benefit purposes. Thus, an individual who is both a 2-percent shareholder of an S corporation and a common law employee of that S corporation is not considered an employee for purposes of section 132(f). However, while section 132(f) does not apply to individuals who are partners, 2-percent shareholders of S corporations, or independent contractors, other exclusions for working condition and de minimis fringes may be available as described in paragraphs (b) and (c) of this Q/A–24. See §§ 1.132–1(b)(2) and 1.132–1(b)(4).

(b) *Transit passes.* The working condition and de minimis fringe exclusions under section 132(a)(3) and (4) are available for transit passes provided to individuals who are partners, 2-percent shareholders, and independent contractors. For example, tokens or farecards provided by a partnership to an individual who is a partner that enable the partner to commute on a public transit system (not including privately-operated van pools) are excludable from the partner's gross income if the value of the tokens and farecards in any month does not exceed the dollar amount specified in § 1.132–6(d)(1). However, if the value of a pass provided in a month exceeds the dollar amount specified in § 1.132–6(d)(1), the full value of the benefit provided (not merely the amount in excess of the dollar amount specified in § 1.132–6(d)(1)) is includible in gross income.

(c) *Parking.* The working condition fringe rules under section 132(d) do not apply to commuter parking. See § 1.132–5(a)(1). However, the de minimis fringe rules under section 132(e) are available for parking provided to individuals who are partners, 2-percent shareholders, or independent contractors that qualifies under the de minimis rules. See § 1.132–6(a) and (b).

(d) *Example.* The following example illustrates the principles of this Q/A–24:

Example. (i) Individual G is a partner in partnership P. Individual G commutes to and from G's office every day and parks free of charge in P's lot.

(ii) In this *Example,* the value of the parking is not excluded under section 132(f), but may be excluded under section 132(e) if the parking is a de minimis fringe under § 1.132–6.

Q–25. What is the effective date of this section?

A–25. (a) Except as provided in paragraph (b) of this Q/A–25, this section is applicable for taxable years beginning after December 31, 2001.

(b) The last sentence of paragraph (b)(5) of Q/A–16 of this section (relating to whether transit system vouchers for transit passes are readily available) is effective for taxable years beginning after December 31, 2003.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 5. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 6. In § 602.101, paragraph (b) is amended by adding an entry in numerical order to the table to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b)

CFR part or section where identified and described	Current OMB control No.
* * * * *	
1.132–9(b)	1545–1676
* * * * *	

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 29, 2000.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

[FR Doc. 01–294 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 602

[TD 8936]

RIN 1545–AW17

Definition of Contribution in Aid of Construction Under Section 118(c)

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations.

SUMMARY: This document contains final regulations concerning an exclusion from gross income for a contribution in aid of construction under section 118(c) that is treated as a contribution to capital under section 118(a). The final regulations affect a regulated public utility that provides water or sewerage services because a qualifying contribution in aid of construction is treated as a contribution to the capital of the utility and excluded from gross income. The final regulations provide guidance on the definition of a contribution in aid of construction, the adjusted basis of any property acquired with a contribution in aid of construction, the information relating to a contribution in aid of construction required to be furnished by the utility, and the time and manner for providing that information to the IRS.

DATES: *Effective Date:* These regulations are effective January 11, 2001.

Date of Applicability: For date of applicability of § 1.118–2, see § 1.118–2(f).

FOR FURTHER INFORMATION CONTACT: Paul Handleman, (202) 622–3040 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

The collections of information contained in these final regulations have been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) under control number 1545–1639. Responses to these collections of information are mandatory.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number.

The estimated annual burden per respondent varies from .5 hour to 5 hours, depending on individual circumstances, with an estimated average of 1 hour.

Comments concerning the accuracy of these burden estimates and suggestions for reducing these burdens should be sent to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, W:CAR:MP:FP:S:O, Washington, DC 20224, and to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503.

Books or records relating to this collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Background

On December 20, 1999, the IRS published proposed regulations (REG–106012–98) in the **Federal Register** (64 FR 71082) inviting comments under section 118(c). A public hearing was held April 27, 2000. Numerous comments have been received. After consideration of all the comments, the proposed regulations are adopted as revised by this Treasury decision.

Summary of Comments

Under section 118(a), gross income does not include any contribution to the capital of the taxpayer. Section 118(c)(1) provides that a contribution to the capital of a taxpayer includes any amount of money or other property received from any person (whether or not a shareholder) by a regulated public utility that provides water or sewerage disposal services if the amount is a contribution in aid of construction, satisfies the expenditure rule, and is not included in rate base for ratemaking purposes. Pursuant to the authority granted to the Secretary under section 118(c)(3)(A), the proposed regulations define a *contribution in aid of construction* as any amount of money or other property contributed to a regulated public utility that provides water or sewerage disposal services to the extent that the purpose of the contribution is to provide for the expansion, improvement, or replacement of the utility's water or sewerage disposal facilities.

Customer Connection Fees

The proposed regulations define nontaxable contributions in aid of construction to exclude customer connection fees. Customer connection fees are defined in the proposed regulations to include amounts paid for the cost of installing a connection or service line (including the cost of meters and piping) from the utility's main lines to the lines owned by the customer, unless the connection or service line serves, or is designed to serve, more than one customer. Customer connection fees also are defined in the proposed regulations to include any amounts paid as service charges for starting or stopping services.

Several commentators contend that connection and service lines should not be treated as taxable customer connection fees for a number of reasons. For example, these commentators argue that the omission from the current law of the language included in former section 118(b)(3)(A) that directed the Secretary to define a contribution in aid of construction to exclude amounts paid to connect the customer's line to a main water or sewer line signals congressional intent to include connection and service lines in the definition of a nontaxable contribution in aid of construction. In addition, some of these commentators believe that the inclusion of connection and service lines as taxable customer connection fees is inconsistent with the judicial interpretation of a contribution in aid of construction, which arguably would treat contributions for main lines and connection and service lines as taxable prerequisites for services under the Supreme Court's decision in *United States* v. *Chicago, Burlington & Quincy R.R.*, 412 U.S. 401 (1973) (1973–2 C.B. 428). Some of these commentators also contend that the exclusion of connection and service lines from the definition of a nontaxable contribution in aid of construction is inconsistent with regulatory accounting treatment, which does not distinguish between main lines and connection and service lines for purposes of classifying property or for purposes of ratemaking. Finally, a few of these commentators point out that the inclusion of connection and service lines as taxable customer connection fees will result in customers being required to gross-up their contributions of connection and service lines for taxes, increasing the cost of housing and development and creating a competitive disadvantage for investor-owned utilities.

The IRS and Treasury Department do not agree with the commentators' position with respect to connection and service lines. As explained in the preamble to the proposed regulations, the inclusion of connection and service lines in the definition of taxable customer connection fees is consistent with the legislative history explanation that section 118(c) was intended to restore the contribution in aid of construction provision of former section

118(b) that was repealed by The Tax Reform Act of 1986 for regulated public utilities that provide water or sewerage disposal services. H.R. Conf. Rep. No. 737, 104th Cong., 2d Sess. 316 (1996) (1996–3 C.B. 741, 1056). While the language regarding the definition of a contribution in aid of construction did change from the language in former section 118(b), Congress did not explicitly include connection and service lines in the definition of a contribution in aid of construction but instead directed the Secretary to define a contribution in aid of construction, presumably aware of the IRS' and Treasury Department's position that connection and service lines are taxable customer connection fees based on Rev. Rul. 75–557 (1975–2 C.B. 33), and the proposed regulations under former section 118(b) (43 FR 22997 (May 30, 1978)). Moreover, the IRS and Treasury Department continue to believe that the exclusion of connection and service lines from a nontaxable contribution in aid of construction is more consistent with the judicial and regulatory interpretation of a contribution in aid of construction and with the Supreme Court's directive that exclusions be narrowly construed. See, for example, *Edwards* v. *Cuba R.R.*, 268 U.S. 628 (1925) (IV–2 C.B. 122); *Detroit Edison Co.* v. *Commissioner*, 319 U.S. 98 (1943) (1943 C.B. 1019); *Chicago, Burlington & Quincy R.R.*, 412 U.S. at 401; *Florida Progress Corp.* v. *United States*, No. 93–246–CIV–T–25A (M.D. Fla. July 2, 1998), *appeal docketed,* No. 99–15389–FF (11th Cir. Dec. 29, 1999); *Commissioner* v. *Schleier*, 515 U.S. 323, 328 (1995); and Rev. Rul. 75–557. As explained by the court in *Teco Energy, Inc.* v. *United States*, No. 98–430–Civ–J–TJC (M.D. Fla. Oct. 21, 1999), ''former [section] 118(b) codifies the principles of *Edwards* that payments made by a government or other group to a utility to encourage the extension of facilities into new areas benefiting a large number of people are given tax free status, while also affirming the reasoning of *Detroit Edison* Revenue Ruling 75–557, that payments made by an individual or business entity to a utility as a prerequisite to receiving water or sewage services would be treated as taxable income to the utility.'' Further, the IRS and Treasury Department believe that the definition of a contribution in aid of construction used for regulatory accounting purposes should not control for tax purposes. See, for example, *Thor Power Tool Co.* v. *Commissioner*, 439 U.S. 522, 541–45 (1979) (1979–1 C.B. 167). Accordingly, the final regulations retain the exclusion of connection and service lines from the definition of a nontaxable contribution in aid of construction.

Some commentators state that, before the proposed regulations were published, some utilities took the position that payments for connection and service lines were not taxable and did not charge their contributors a sufficient amount to cover their tax liabilities. The IRS and Treasury Department understand that there was uncertainty before the proposed regulations were published and that some utilities may have reasonably interpreted section 118(c)(3)(A) to mean that connection and service lines should not be treated as taxable. It is clear that these final regulations apply to money and other property received on or after January 11, 2001 and do not apply to transactions entered into prior to that date. In addition, the IRS will take into account all the facts and circumstances in applying section 118(c) to such transactions.

Commentators suggest that customer connection fees relating to services provided to public authorities, such as schools, hospitals, public libraries, and governmental entities, should be included in the definition of nontaxable contributions in aid of construction because these services provide a broad public benefit. In addition, commentators recommend that customer connection fees relating to fire protection services should qualify as nontaxable contributions in aid of construction because a utility receives no revenue for public fire protection services and only a nominal standby fee for private fire protection services. The IRS and Treasury Department believe that, regardless of whether the activities of public authorities provide a public benefit, connection and service lines that serve these customers should be treated in the same manner as connection or service lines to any paying customer—as a prerequisite for services. Consequently, the final regulations continue to treat amounts paid for connection and service lines with respect to public authorities as customer connection fees. However, the IRS and the Treasury Department agree with commentators that amounts paid with respect to fire protection services should not be considered customer connection fees.

Several commentators suggest that connection and service lines that serve more than one user, such as lines for apartment houses, condominium projects, shopping malls, and office buildings, should be considered to serve more than one customer and, thus, be excluded from taxable customer connection fees, regardless of whether the utility treats the facility as one customer or many. The final regulations do not adopt this suggestion because whether connection or service lines are designed to serve more than one customer does not depend on the number of users but upon the number of customers. Thus, for example, if a water or sewerage disposal utility treats an apartment or office building as one utility customer, then the cost of connecting the utility's main lines to the connection or service lines serving that single customer is a taxable customer connection fee.

Binding Agreement Rule

The proposed regulations provide that if a water or sewerage disposal facility is placed in service by the utility before an amount is contributed to the utility, the contribution is not a nontaxable contribution in aid of construction unless, at the time the facility is placed in service by the utility, there is an agreement, binding under local law between the prospective contributor and the utility, that the utility is to receive the amount as reimbursement for the cost of acquiring or constructing the facility.

Commentators suggest that the binding agreement rule should be expanded to include enforceable public utility commission orders and tariffs. The final regulations adopt this suggestion by treating an order or a tariff, issued or approved by the applicable public utility commission, that requires a current or prospective customer to reimburse the utility for the cost of acquiring or constructing the facility as a binding agreement. Because public utility commission orders or tariffs may be issued or approved before or after the facility is placed in service, the final regulations also extend the time for entering into a binding agreement or the issuance or approval of an order or a tariff to no later than 8½ months after the close of the taxable year (the usual due date with extensions for a taxpayer's return) in which the facility is placed in service.

One commentator suggests adding an example demonstrating that payments made pursuant to a binding agreement qualify as a contribution in aid of construction under section 118(c). The final regulations adopt this suggestion.

Basis Rules

The proposed regulations provide that the basis of a water or sewerage facility acquired or constructed with a contribution under a binding agreement must be reduced by the amount of the contribution at the time the facility is

placed in service. Several commentators suggest that if the receipt of all of the expected contributions under the agreement occurs more than one or two years after a facility is placed in service, the utility should be permitted to claim the full cost of the facility as basis for depreciation purposes, subject to adjustment as the contributions are received. The final regulations do not adopt this comment because section 118(c)(4) disallows any depreciation deductions for a water or sewerage disposal facility that is fully paid with a nontaxable contribution in aid of construction under section under section 118(c). This result is consistent with similar rules that either exclude expected contributions from basis or deny a deduction to the extent the taxpayer has a right to, or reasonable prospect of, reimbursement. See, for example, § 1.110–1(b)(4)(ii)(B); § 1.165–1(d)(2)(i); and Rev. Rul. 79–263 (1979–2 C.B. 82).

The proposed regulations provide that, if a contribution in aid of construction treated as a contribution to the capital of the taxpayer is repaid to the contributor, either in whole or in part, then the repayment amount is a capital expenditure in the taxable year in which it is paid or incurred, resulting in an increase in the property's adjusted basis in such year. A couple of commentators suggest that the repayment should be depreciated over the remaining life of the property. The final regulations adopt this suggestion.

Reporting Requirement

The proposed regulations provide that a taxpayer treating a contribution in aid of construction as a contribution to capital must file a statement with its tax returns to report the amount of the contribution in aid of construction the taxpayer: (1) Expended during the taxable year for property described in section 118(c)(2)(A) (qualified property); (2) does not intend to expend for qualified property; and (3) failed to expend for qualified property. Several commentators express concern that the reporting requirement in the proposed regulations exceeds the intent of the statute because section 118(c)(2)(C) only requires the maintenance of adequate records. However, section 118(d)(1) provides that if the taxpayer for any taxable year treats an amount as a contribution to the capital of the taxpayer described in section 118(c), then the statutory period for the assessment of any deficiency attributable to any part of the amount does not expire before the expiration of 3 years from the date the Secretary is notified by the taxpayer (in such manner as the Secretary may prescribe) of the amount of the expenditure referred to in section 118(c)(2)(A), of the taxpayer's intention not to make the expenditures referred to in section 118(c)(2)(A), or of a failure to make the expenditure within the period described in section 118(c)(2)(B). Thus, the regulations do not impose an additional reporting requirement but merely provide the time and manner in which taxpayers must notify the Secretary under section 118(d)(1) of amounts treated as contributions in aid of construction.

Collection of Information under Paperwork Reduction Act

Two comments were sent to OMB on the collection of information contained in the proposed regulations, with copies of the comments sent to the IRS Reports Clearance Officer. The commentators estimate that complying with the recordkeeping requirements of section 118(c)(2)(C) involves more hours and that the number of respondents is greater than estimated. The collection of information burden under the proposed regulations is based only upon the time for notifying the IRS of the required information under section 118(d)(1) and is not required to include the time for maintaining accurate books and records. Thus, the individual time to comply with the collection of information burden was not increased to reflect these commentators concerns. However, the estimated number of annual respondents has been increased to 300 and the estimated total annual reporting burden has been increased to 300 hours.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. It is hereby certified that the collection of information in these regulations will not have a significant economic impact on a substantial number of small entities. This certification is based upon the fact that any burden on taxpayers is minimal. Accordingly, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Paul F. Handleman, Office of the Associate Chief Counsel (Passthroughs and Special Industries), IRS. However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 602 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding an entry in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *
Section 1.118–2 also issued under 26 U.S.C. 118(c)(3)(A); * * *

Par. 2. Section 1.118–2 is added to read as follows:

§ 1.118–2 Contribution in aid of construction.

(a) *Special rule for water and sewerage disposal utilities*—(1) *In general.* For purposes of section 118, the term *contribution to the capital of the taxpayer* includes any amount of money or other property received from any person (whether or not a shareholder) by a regulated public utility that provides water or sewerage disposal services if—

(i) The amount is a contribution in aid of construction under paragraph (b) of this section;

(ii) In the case of a contribution of property other than water or sewerage disposal facilities, the amount satisfies the expenditure rule under paragraph (c) of this section; and

(iii) The amount (or any property acquired or constructed with the amount) is not included in the taxpayer's rate base for ratemaking purposes.

(2) *Definitions*—(i) *Regulated public utility* has the meaning given such term by section 7701(a)(33), except that such term does not include any utility which is not required to provide water or sewerage disposal services to members of the general public in its service area.

(ii) *Water or sewerage disposal facility* is defined as tangible property described in section 1231(b) that is used predominately (80% or more) in the trade or business of furnishing water or sewerage disposal services.

(b) *Contribution in aid of construction*—(1) *In general.* For purposes of section 118(c) and this section, the term *contribution in aid of construction* means any amount of money or other property contributed to a regulated public utility that provides water or sewerage disposal services to the extent that the purpose of the contribution is to provide for the expansion, improvement, or replacement of the utility's water or sewerage disposal facilities.

(2) *Advances.* A contribution in aid of construction may include an amount of money or other property contributed to a regulated public utility for a water or sewerage disposal facility subject to a contingent obligation to repay the amount, in whole or in part, to the contributor (commonly referred to as an advance). For example, an amount received by a utility from a developer to construct a water facility pursuant to an agreement under which the utility will pay the developer a percentage of the receipts from the facility over a fixed period may constitute a contribution in aid of construction. Whether an advance is a contribution or a loan is determined under general principles of federal tax law based on all the facts and circumstances. For the treatment of any amount of a contribution in aid of construction that is repaid by the utility to the contributor, see paragraphs (c)(2)(ii) and (d)(2) of this section.

(3) *Customer connection fee*—(i) *In general.* Except as provided in paragraph (b)(3)(ii) of this section, a customer connection fee is not a contribution in aid of construction under this paragraph (b) and generally is includible in income. The term *customer connection fee* includes any amount of money or other property transferred to the utility representing the cost of installing a connection or service line (including the cost of meters and piping) from the utility's main water or sewer lines to the line owned by the customer or potential customer. A customer connection fee also includes any amount paid as a service charge for starting or stopping service.

(ii) *Exceptions*—(A) *Multiple customers.* Money or other property contributed for a connection or service line from the utility's main line to the customer's or the potential customer's line is not a customer connection fee if the connection or service line serves, or is designed to serve, more than one customer. For example, a contribution for a split service line that is designed to serve two customers is not a customer connection fee. On the other hand, if a water or sewerage disposal utility treats an apartment or office building as one utility customer, then the cost of installing a connection or service line from the utility's main water or sewer lines serving that single customer is a customer connection fee.

(B) *Fire protection services.* Money or other property contributed for public and private fire protection services is not a customer connection fee.

(4) *Reimbursement for a facility previously placed in service*—(i) *In general.* If a water or sewerage disposal facility is placed in service by the utility before an amount is contributed to the utility, the contribution is not a contribution in aid of construction under this paragraph (b) with respect to the cost of the facility unless, no later than 8½ months after the close of the taxable year in which the facility was placed in service, there is an agreement, binding under local law, that the utility is to receive the amount as reimbursement for the cost of acquiring or constructing the facility. An order or tariff, binding under local law, that is issued or approved by the applicable public utility commission requiring current or prospective utility customers to reimburse the utility for the cost of acquiring or constructing the facility, is a binding agreement for purposes of the preceding sentence. If an agreement exists, the basis of the facility must be reduced by the amount of the expected contributions. Appropriate adjustments must be made if actual contributions differ from expected contributions.

(ii) *Example.* The application of paragraph (b)(4)(i) of this section is illustrated by the following example:

Example. M, a calendar year regulated public utility that provides water services, spent $1,000,000 for the construction of a water facility that can serve 200 customers. M placed the facility in service in 2000. In June 2001, the public utility commission that regulates M approves a tariff requiring new customers to reimburse M for the cost of constructing the facility by paying a service availability charge of $5,000 per lot. Pursuant to the tariff, M expects to receive reimbursements for the cost of the facility of $100,000 per year for the years 2001 through 2010. The reimbursements are contributions in aid of construction under paragraph (b) of this section because no later than 8½ months after the close of the taxable year in which the facility was placed in service there was a tariff, binding under local law, approved by the public utility commission requiring new customers to reimburse the utility for the cost of constructing the facility. The basis of the $1,000,000 facility is zero because the expected contributions equal the cost of the facility.

(5) *Classification by ratemaking authority.* The fact that the applicable ratemaking authority classifies any money or other property received by a utility as a contribution in aid of construction is not conclusive as to its treatment under this paragraph (b).

(c) *Expenditure rule*—(1) *In general.* An amount satisfies the expenditure rule of section 118(c)(2) if the amount is expended for the acquisition or construction of property described in section 118(c)(2)(A), the amount is paid or incurred before the end of the second taxable year after the taxable year in which the amount was received as required by section 118(c)(2)(B), and accurate records are kept of contributions and expenditures as provided in section 118(c)(2)(C).

(2) *Excess amount*—(i) *Includible in the utility's income.* An amount received by a utility as a contribution in aid of construction that is not expended for the acquisition or construction of water or sewerage disposal facilities as required by paragraph (c)(1) of this section (the excess amount) is not a contribution to the capital of the taxpayer under paragraph (a) of this section. Except as provided in paragraph (c)(2)(ii) of this section, such excess amount is includible in the utility's income in the taxable year in which the amount was received.

(ii) *Repayment of excess amount.* If the excess amount described in paragraph (c)(2)(i) of this section is repaid, in whole or in part, either—

(A) Before the end of the time period described in paragraph (c)(1) of this section, the repayment amount is not includible in the utility's income; or

(B) After the end of the time period described in paragraph (c)(1) of this section, the repayment amount may be deducted by the utility in the taxable year in which it is paid or incurred to the extent such amount was included in income.

(3) *Example.* The application of this paragraph (c) is illustrated by the following example:

Example. M, a calendar year regulated public utility that provides water services, received a $1,000,000 contribution in aid of construction in 2000 for the purpose of constructing a water facility. To the extent that the $1,000,000 exceeded the actual cost of the facility, the contribution was subject to being returned. In 2001, M built the facility at a cost of $700,000 and returned $200,000 to the contributor. As of the end of 2002, M had not returned the remaining $100,000. Assuming accurate records are kept, the requirement under section 118(c)(2) is satisfied for $700,000 of the contribution.

Because $200,000 of the contribution was returned within the time period during which qualifying expenditures could be made, this amount is not includible in M's income. However, the remaining $100,000 is includible in M's income for its 2000 taxable year (the taxable year in which the amount was received) because the amount was neither spent nor repaid during the prescribed time period. To the extent M repays the remaining $100,000 after year 2002, M would be entitled to a deduction in the year such repayment is paid or incurred.

(d) *Adjusted basis*—(1) *Exclusion from basis.* Except for a repayment described in paragraph (d)(2) of this section, to the extent that a water or sewerage disposal facility is acquired or constructed with an amount received as a contribution to the capital of the taxpayer under paragraph (a) of this section, the basis of the facility is reduced by the amount of the contribution. To the extent the water or sewerage disposal facility is acquired as a contribution to the capital of the taxpayer under paragraph (a) of this section, the basis of the contributed facility is zero.

(2) *Repayment of contribution.* If a contribution to the capital of the taxpayer under paragraph (a) of this section is repaid to the contributor, either in whole or in part, then the repayment amount is a capital expenditure in the taxable year in which it is paid or incurred, resulting in an increase in the property's adjusted basis in such year. Capital expenditures allocated to depreciable property under paragraph (d)(3) of this section may be depreciated over the remaining recovery period for that property.

(3) *Allocation of contributions.* An amount treated as a capital expenditure under this paragraph (d) is to be allocated proportionately to the adjusted basis of each property acquired or constructed with the contribution based on the relative cost of such property.

(4) *Example.* The application of this paragraph (d) is illustrated by the following example:

Example. A, a calendar year regulated public utility that provides water services, received a $1,000,000 contribution in aid of construction in 2000 as an advance from B, a developer, for the purpose of constructing a water facility. To the extent that the $1,000,000 exceeds the actual cost of the facility, the contribution is subject to being returned. Under the terms of the advance, A agrees to pay to B a percentage of the receipts from the facility over a fixed period, but limited to the cost of the facility. In 2001, A builds the facility at a cost of $700,000 and returns $300,000 to B. In 2002, A pays $20,000 to B out of the receipts from the facility. Assuming accurate records are kept, the $700,000 advance is a contribution to the capital of A under paragraph (a) of this section and is excludable from A's income. The basis of the $700,000 facility constructed with this contribution to capital is zero. The $300,000 excess amount is not a contribution to the capital of A under paragraph (a) of this section because it does not meet the expenditure rule described in paragraph (c)(1) of this section. However, this excess amount is not includible in A's income pursuant to paragraph (c)(2)(ii) of this section since the amount is repaid to B within the required time period. The repayment of the $300,000 excess amount to B in 2001 is not treated as a capital expenditure by A. The $20,000 payment to B in 2002 is treated as a capital expenditure by A in 2002 resulting in an increase in the adjusted basis of the water facility from zero to $20,000.

(e) *Statute of limitations*—(1) *Extension of statute of limitations.* Under section 118(d)(1), the statutory period for assessment of any deficiency attributable to a contribution to capital under paragraph (a) of this section does not expire before the expiration of 3 years after the date the taxpayer notifies the Secretary in the time and manner prescribed in paragraph (e)(2) of this section.

(2) *Time and manner of notification.* Notification is made by attaching a statement to the taxpayer's federal income tax return for the taxable year in which any of the reportable items in paragraphs (e)(2)(i) through (iii) of this section occur. The statement must contain the taxpayer's name, address, employer identification number, taxable year, and the following information with respect to contributions of property other than water or sewerage disposal facilities that are subject to the expenditure rule described in paragraph (c) of this section—

(i) The amount of contributions in aid of construction expended during the taxable year for property described in section 118(c)(2)(A) (qualified property) as required under paragraph (c)(1) of this section, identified by taxable year in which the contributions were received;

(ii) The amount of contributions in aid of construction that the taxpayer does not intend to expend for qualified property as required under paragraph (c)(1) of this section, identified by taxable year in which the contributions were received; and

(iii) The amount of contributions in aid of construction that the taxpayer failed to expend for qualified property as required under paragraph (c)(1) of this section, identified by taxable year in which the contributions were received.

(f) *Effective date.* This section is applicable for any money or other property received by a regulated public utility that provides water or sewerage disposal services on or after January 11, 2001.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

Par. 3. The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 4. In § 602.101, paragraph (b) is amended by adding an entry to the table in numerical order to read as follows:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section identified and described	Current OMB control No.
* * * * *	
1.118–2	1545–1639
* * * * *	

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 20, 2000.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

[FR Doc. 01–487 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 1 and 7

[TD 8937]

RIN 1545–AY53

Stock Transfer Rules: Transition Rules

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document contains final regulations addressing distributions with respect to, or a disposition of, certain stock that was subject to prior temporary regulations under section 367(b). Section 367(b) addresses the application of nonrecognition exchange provisions in Subchapter C of the Internal Revenue Code to transactions that involve one or more foreign corporations.

DATES: *Effective Date.* These regulations are effective as of January 11, 2001.

Applicability Dates. These regulations apply to distributions or dispositions that occur on or after January 11, 2001.

FOR FURTHER INFORMATION CONTACT: Mark D. Harris, (202) 622–3860 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

On January 24, 2000, the IRS and Treasury issued final regulations under section 367(b) of the Internal Revenue Code (Code). At the same time, the IRS and Treasury also modified temporary regulation § 7.367(b)-12(a). The final regulations and modified temporary regulation were effective as of February 23, 2000.

As modified, § 7.367(b)-12(a) addresses distributions with respect to, or a disposition of, stock that was subject to certain provisions of the temporary section 367(b) regulations that were in effect before February 23, 2000. This document finalizes the rule stated in § 7.367(b)-12(a) in order to insure its continued application. See section 7805(e)(2) (stating a ''sunset rule'' applicable to temporary regulations).

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because the notice of proposed rulemaking preceding the regulations was issued prior to March 29, 1996, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply.

Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on the impact of the proposed regulations on small business.

Drafting Information

The principal author of these regulations is Mark Harris of the Office of Associate Chief Counsel (International). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects 26 CFR Parts 1 and 7

Income taxes, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR parts 1 and 7 are amended as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 is amended by adding an entry in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 1.367(b)–12 also issued under 26 U.S.C. 367(a) and (b). * * *

Par. 2. Section 1.367(b)–0 is amended by revising the introductory text and adding entries for § 1.367(b)–12 to read as follows:

§ 1.367(b)–0 Table of contents.

This section lists the paragraphs contained in §§ 1.367(b)–1 through 1.367(b)–6 and 1.367(b)–12.

* * * * *

§ 1.367(b)–12 Subsequent treatment of amounts attributed or included in income.

(a) In general.
(b) Applicable rules.
(c) Effective date.

Par. 3. Section 1.367(b)–12 is added to read as follows:

§ 1.367(b)–12 Subsequent treatment of amounts attributed or included in income.

(a) *In general.* This section applies to distributions with respect to, or a disposition of, stock—

(1) To which, in connection with an exchange occurring before February 23, 2000, an amount has been attributed pursuant to § 7.367(b)–9 or 7.367(b)–10 of this chapter (as in effect prior to February 23, 2000, see 26 CFR part 1 revised as of April 1, 1999); or

(2) In respect of which, before February 23, 2000, an amount has been included in income or added to earnings and profits pursuant to § 7.367(b)–7 or § 7.367(b)–10 of this chapter (as in effect prior to February 23, 2000, see 26 CFR part 1 revised as of April 1, 1999).

(b) *Applicable rules.* See § 7.367(b)–12(b) through (e) of this chapter (as in effect prior to January 11, 2001, see 26 CFR part 1 revised as of April 1, 2000) for purposes of applying paragraph (a) of this section.

(c) *Effective date.* This section applies to distributions or dispositions that occur on or after January 11, 2001.

PART 7—TEMPORARY INCOME TAX REGULATIONS UNDER THE TAX REFORM ACT OF 1976

Par. 4. The authority citation for part 7 is amended by removing the entry for § 7.367(b)–12 and continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

§ 7.367(b)–12 [Removed]

Par. 5. Section 7.367(b)–12 is removed.

Approved: December 28, 2000

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Jonathan Talisman,

Assistant Secretary of the Treasury.

[FR Doc. 01–488 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[TD 8932]

RIN 1545–AW81

Timely Mailing Treated as Timely Filing/Electronic Postmark

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations; and removal of temporary regulations.

SUMMARY: This document contains regulations relating to timely mailing treated as timely filing and paying under section 7502 of the Internal Revenue Code. The regulations generally reflect changes to the law made since 1960. In addition, the regulations provide that the date of an electronic postmark will be the filing date under certain circumstances. The regulations affect taxpayers who file documents or make payments or deposits.

DATES: *Effective Date:* These regulations are effective January 11, 2001.

Applicability Date: For dates of applicability, see §§ 301.7502–1(g) and 301.7502–2(e).

FOR FURTHER INFORMATION CONTACT: Charles A. Hall, (202) 622–4940 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

This document contains amendments to the Regulations on Procedure and Administration (26 CFR part 301) under section 7502 relating to timely mailing treated as timely filing and paying. A notice of proposed rulemaking (REG–115433–98) was published in the **Federal Register** (64 FR 2606) on January 15, 1999. Temporary regulations (TD 8807) relating to electronic postmarks for electronically filed income tax returns were published in the **Federal Register** for the same day (64 FR 2568). No public hearing was requested or held. No comments were received from the public in response to the notice of proposed rulemaking. The proposed regulations under section

7502 are adopted as revised by this Treasury decision and the corresponding temporary regulations are removed. The revisions are discussed below.

Explanation of Revisions

In the notice of proposed rulemaking, the IRS and the Treasury Department requested comments regarding whether section 7502 should apply to claims for credit or refund made on late filed original income tax returns. No comments were received on this issue. However, the IRS and the Treasury Department have determined that, in certain situations, a claim for credit or refund made on a late filed original income tax return should be treated under section 7502 as timely filed on the postmark date for purposes of section 6511(b)(2)(A). This is consistent with the opinion of the United States Court of Appeals for the Second Circuit in *Weisbart* v. *United States Department of Treasury and Internal Revenue Service,* 222 F.3d 93 (2d Cir. 2000), *rev'g* 99–1 USTC (CCH) ¶ 50,549 (E.D.N.Y. 1999), AOD–CC–2000–09 (Nov. 13, 2000).

The IRS and the Treasury Department have further determined that claims for credit or refund made on late filed original tax returns other than income tax returns should also be treated under section 7502 as timely filed on the postmark date for purposes of section 6511(b)(2)(A). This would include returns such as Form 720, Quarterly Federal Excise Tax Return, and Form 706, U.S. Estate Tax Return. Moreover, the IRS and the Treasury Department have determined that the late filed original tax return, as well as the claim for credit or refund, should also be treated as filed on the postmark date. These changes, which are reflected in § 301.7502–1(f), will assist taxpayers in filing timely claims for credit or refund, and will be applied retroactively to certain previously disallowed claims for credit or refund.

These changes are effective for any claim for credit or refund on a late filed tax return described in § 301.7502–1(f)(1) except for those claims for credit or refund which (without regard to paragraph (f) of this section) were barred by the operation of section 6532(a) or any other law or rule of law (including res judicata) as of January 11, 2001. See § 301.7502–1(g)(2), which provides the effective date rules for § 301.7502–1(f).

Consistent with the effective date rules for § 301.7502–1(f), the IRS will attempt to identify as many claims as possible that were filed on untimely original individual income tax returns and that were previously disallowed based on the Government's position in *Weisbart*. In these cases, the IRS intends to issue a refund, or credit the overpayment against a liability as provided in section 6402, without the need for the taxpayer to contact the IRS. Such automatic reconsideration of the claim will generally occur if the claim was filed on an individual income tax return for 1995 or a subsequent calendar year. Claims filed on other types of original returns will not receive automatic reconsideration under this program, *e.g.,* individual returns for years prior to 1995.

Because the IRS will be undertaking the automatic reconsideration program described above and intends to complete the program by June 30, 2001, taxpayers who have filed income tax refund claims for tax year 1995 and later years that qualify under § 301.7502–1(f) need not contact the IRS regarding their claims unless the two-year period for filing a refund suit under section 6532(a) for their denied claim will expire prior to June 30, 2001. In such cases, taxpayers are advised to file a request for reconsideration with the appropriate IRS Service Center. Such a request should include a notation on the top of the first page that it is a ''*Weisbart* Claim.'' Such taxpayers are also advised to file a refund suit to protect their legal rights with respect to the claim. The IRS will respond to the requests for reconsideration after the IRS has finished identifying eligible claims under the automatic reconsideration program and paying those refunds. Taxpayers whose two-year period for filing a refund suit under section 6532(a) does not expire until after June 30, 2001, and who have not received a refund by that date, are advised to file a request for reconsideration with the appropriate IRS Service Center at that time.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It also has been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations, and because these regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Internal Revenue Code, the notice of proposed rulemaking preceding these regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these regulations is Charles A. Hall of the Office of Associate Chief Counsel, Procedure and Administration (Administrative Provisions and Judicial Practice Division). However, other personnel from the IRS and Treasury Department participated in their development.

List of Subjects in 26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 301 is amended as follows:

PART 301—PROCEDURE AND ADMINISTRATION

Paragraph 1. The authority citation for part 301 is amended by adding entries in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

Section 301.7502–1 also issued under 26 U.S.C. 7502.

Section 301.7502–2 also issued under 26 U.S.C. 7502.

* * * * *

Par. 2. Section 301.7502–1 is revised to read as follows:

§ 301.7502–1 Timely mailing of documents and payments treated as timely filing and paying.

(a) *General rule.* Section 7502 provides that, if the requirements of that section are met, a document or payment is deemed to be filed or paid on the date of the postmark stamped on the envelope or other appropriate wrapper (envelope) in which the document or payment was mailed. Thus, if the envelope that contains the document or payment has a timely postmark, the document or payment is considered timely filed or paid even if it is received after the last date, or the last day of the period, prescribed for filing the document or making the payment. Section 7502 does not apply in determining whether a failure to file a return or pay a tax has continued for an additional month or fraction thereof for purposes of computing the penalties and additions to tax imposed by section 6651. Except as provided in section 7502(e) and § 301.7502–2, relating to the timely mailing of deposits, and paragraph (d) of this section, relating to

electronically filed documents, section 7502 is applicable only to those documents or payments as defined in paragraph (b) of this section and only if the document or payment is mailed in accordance with paragraph (c) of this section and is delivered in accordance with paragraph (e) of this section.

(b) *Definitions*—(1) *Document defined.* (i) The term *document,* as used in this section, means any return, claim, statement, or other document required to be filed within a prescribed period or on or before a prescribed date under authority of any provision of the internal revenue laws, except as provided in paragraph (b)(1)(ii), (iii), or (iv) of this section.

(ii) The term does not include returns, claims, statements, or other documents that are required under any provision of the internal revenue laws or the regulations thereunder to be delivered by any method other than mailing.

(iii) The term does not include any document filed in any court other than the Tax Court, but the term does include any document filed with the Tax Court, including a petition and a notice of appeal of a decision of the Tax Court.

(iv) The term does not include any document that is mailed to an authorized financial institution under section 6302. However, see § 301.7502–2 for special rules relating to the timeliness of deposits and documents required to be filed with deposits.

(2) *Claims for refund.* In the case of certain taxes, a return may constitute a claim for credit or refund. In such a case, section 7502 is applicable to the claim for credit or refund if the conditions of such section are met, irrespective of whether the claim is also a return. For rules regarding claims for refund on late filed tax returns, see paragraph (f) of this section.

(3) *Payment defined.* (i) The term *payment,* as used in this section, means any payment required to be made within a prescribed period or on or before a prescribed date under the authority of any provision of the internal revenue laws, except as provided in paragraph (b)(3)(ii), (iii), (iv), or (v) of this section.

(ii) The term does not include any payment that is required under any provision of the internal revenue laws or the regulations thereunder to be delivered by any method other than mailing. See, for example, section 6302(h) and the regulations thereunder regarding electronic funds transfer.

(iii) The term does not include any payment, whether it is made in the form of currency or other medium of payment, unless it is actually received and accounted for. For example, if a check is used as the form of payment, this section does not apply unless the check is honored upon presentation.

(iv) The term does not include any payment to any court other than the Tax Court.

(v) The term does not include any deposit that is required to be made with an authorized financial institution under section 6302. However, see § 301.7502–2 for rules relating to the timeliness of deposits.

(4) *Last date or last day prescribed.* As used in this section, the term *the last date, or the last day of the period, prescribed for filing the document or making the payment* includes any extension of time granted for that action. When the last date, or the last day of the period, prescribed for filing the document or making the payment falls on a Saturday, Sunday or legal holiday, section 7503 applies. Therefore, in applying the rules of this paragraph (b)(4), the next succeeding day that is not a Saturday, Sunday, or legal holiday is treated as the last date, or the last day of the period, prescribed for filing the document or making the payment. Also, when the last date, or the last day of the period, prescribed for filing the document or making the payment falls within a period disregarded under section 7508 or section 7508A, the next succeeding day after the expiration of the section 7508 period or section 7508A period that is not a Saturday, Sunday, or legal holiday is treated as the last date, or the last day of the period, prescribed for filing the document or making the payment.

(c) *Mailing requirements*—(1) *In general.* Section 7502 does not apply unless the document or payment is mailed in accordance with the following requirements:

(i) *Envelope and address.* The document or payment must be contained in an envelope, properly addressed to the agency, officer, or office with which the document is required to be filed or to which the payment is required to be made.

(ii) *Timely deposited in U.S. mail.* The document or payment must be deposited within the prescribed time in the mail in the United States with sufficient postage prepaid. For this purpose, a document or payment is deposited in the mail in the United States when it is deposited with the domestic mail service of the U.S. Postal Service. The domestic mail service of the U.S. Postal Service, as defined by the Domestic Mail Manual as incorporated by reference in the postal regulations, includes mail transmitted within, among, and between the United States of America, its territories and possessions, and Army post offices (APO), fleet post offices (FPO), and the United Nations, NY. (See Domestic Mail Manual, section G011.2.1, as incorporated by reference in 39 CFR 111.1.) Section 7502 does not apply to any document or payment that is deposited with the mail service of any other country.

(iii) *Postmark*—(A) *U.S. Postal Service postmark.* If the postmark on the envelope is made by the U.S. Postal Service, the postmark must bear a date on or before the last date, or the last day of the period, prescribed for filing the document or making the payment. If the postmark does not bear a date on or before the last date, or the last day of the period, prescribed for filing the document or making the payment, the document or payment is considered not to be timely filed or paid, regardless of when the document or payment is deposited in the mail. Accordingly, the sender who relies upon the applicability of section 7502 assumes the risk that the postmark will bear a date on or before the last date, or the last day of the period, prescribed for filing the document or making the payment. See, however, paragraph (c)(2) of this section with respect to the use of registered mail or certified mail to avoid this risk. If the postmark on the envelope is made by the U.S. Postal Service but is not legible, the person who is required to file the document or make the payment has the burden of proving the date that the postmark was made. Furthermore, if the envelope that contains a document or payment has a timely postmark made by the U.S. Postal Service, but it is received after the time when a document or payment postmarked and mailed at that time would ordinarily be received, the sender may be required to prove that it was timely mailed.

(B) *Postmark made by other than U.S. Postal Service*—(*1*) *In general.* If the postmark on the envelope is made other than by the U.S. Postal Service—

(*i*) The postmark so made must bear a legible date on or before the last date, or the last day of the period, prescribed for filing the document or making the payment; and

(*ii*) The document or payment must be received by the agency, officer, or office with which it is required to be filed not later than the time when a document or payment contained in an envelope that is properly addressed, mailed, and sent by the same class of mail would ordinarily be received if it were postmarked at the same point of origin by the U.S. Postal Service on the last date, or the last day of the period, prescribed for filing the document or making the payment.

(*2*) *Document or payment received late.* If a document or payment described in paragraph (c)(1)(iii)(B)(*1*) is received after the time when a document or payment so mailed and so postmarked by the U.S. Postal Service would ordinarily be received, the document or payment is treated as having been received at the time when a document or payment so mailed and so postmarked would ordinarily be received if the person who is required to file the document or make the payment establishes—

(*i*) That it was actually deposited in the U.S. mail before the last collection of mail from the place of deposit that was postmarked (except for the metered mail) by the U.S. Postal Service on or before the last date, or the last day of the period, prescribed for filing the document or making the payment;

(*ii*) That the delay in receiving the document or payment was due to a delay in the transmission of the U.S. mail; and

(*iii*) The cause of the delay.

(*3*) *U.S. and non-U.S. postmarks.* If the envelope has a postmark made by the U.S. Postal Service in addition to a postmark not so made, the postmark that was not made by the U.S. Postal Service is disregarded, and whether the envelope was mailed in accordance with this paragraph (c)(1)(iii)(B) will be determined solely by applying the rule of paragraph (c)(1)(iii)(A) of this section.

(2) *Registered or certified mail.* If the document or payment is sent by U.S. registered mail, the date of registration of the document or payment is treated as the postmark date. If the document or payment is sent by U.S. certified mail and the sender's receipt is postmarked by the postal employee to whom the document or payment is presented, the date of the U.S. postmark on the receipt is treated as the postmark date of the document or payment. Accordingly, the risk that the document or payment will not be postmarked on the day that it is deposited in the mail may be eliminated by the use of registered or certified mail.

(d) *Electronically filed documents*—(1) *In general.* A document filed electronically with an electronic return transmitter (as defined in paragraph (d)(3)(i) of this section and authorized pursuant to paragraph (d)(2) of this section) in the manner and time prescribed by the Commissioner is deemed to be filed on the date of the electronic postmark (as defined in paragraph (d)(3)(ii) of this section) given by the authorized electronic return transmitter. Thus, if the electronic postmark is timely, the document is considered filed timely although it is received by the agency, officer, or office after the last date, or the last day of the period, prescribed for filing such document.

(2) *Authorized electronic return transmitters.* The Commissioner may enter into an agreement with an electronic return transmitter or prescribe in forms, instructions, or other appropriate guidance the procedures under which the electronic return transmitter is authorized to provide taxpayers with an electronic postmark to acknowledge the date and time that the electronic return transmitter received the electronically filed document.

(3) *Definitions*—(i) *Electronic return transmitter.* For purposes of this paragraph (d), the term *electronic return transmitter* has the same meaning as contained in section 3.01(4) of Rev. Proc. 2000–31 (2000–31 I.R.B. 146 (July 31, 2000))(see § 601.601(d)(2) of this chapter) or in procedures prescribed by the Commissioner.

(ii) *Electronic postmark.* For purposes of this paragraph (d), the term *electronic postmark* means a record of the date and time (in a particular time zone) that an authorized electronic return transmitter receives the transmission of a taxpayer's electronically filed document on its host system. However, if the taxpayer and the electronic return transmitter are located in different time zones, it is the taxpayer's time zone that controls the timeliness of the electronically filed document.

(e) *Delivery*—(1) Except as provided in section 7502(f) and paragraph (d) of this section, section 7502 is not applicable unless the document or payment is delivered by U.S. mail to the agency, officer, or office with which the document is required to be filed or to which payment is required to be made. However, in the case of a document (but not a payment) sent by registered or certified mail, proof that the document was properly registered or that a postmarked certified mail sender's receipt was properly issued and that the envelope was properly addressed to the agency, officer, or office constitutes prima facie evidence that the document was delivered to the agency, officer, or office.

(2) Section 7502 is applicable to the determination of whether a claim for credit or refund is timely filed for purposes of section 6511(a), assuming all the requirements of section 7502 are satisfied. Section 7502 is also applicable when a claim for credit or refund is delivered after the last day of the period specified in section 6511(b)(2)(A) or in any other corresponding provision of law relating to the limit on the amount of credit or refund that is allowable.

(3) *Example.* The rules of paragraph (e)(2) of this section are illustrated by the following example:

Example. (i) Taxpayer A, an individual, mailed his 1998 Form 1040, ''U.S. Individual Income Tax Return,'' on May 10, 1999, but no tax was paid at that time because the tax liability disclosed by the return had been completely satisfied by the income tax that had been withheld on A's wages. On April 15, 2002, A mails in accordance with the requirements of this section, a Form 1040X, ''U.S. Amended Individual Income Tax Return,'' claiming a refund of a portion of the tax that had been paid through withholding during 1998. The date of the postmark on the envelope containing the claim for refund is April 15, 2002. The claim is received by the Internal Revenue Service (IRS) on April 18, 2002.

(ii) Under section 6511(a), A's claim for refund is timely if filed within three years from May 10, 1999, the date on which A's 1998 return was filed. However, as a result of the limitations of section 6511(b)(2)(A), if his claim is not filed within three years after April 15, 1999, the date on which he is deemed under section 6513 to have paid his 1998 tax, he is not entitled to any refund. Thus, because A's claim for refund is postmarked and mailed in accordance with the requirements of this section and is delivered after the last day of the period specified in section 6511(b)(2)(A), section 7502 is applicable and the claim is deemed to have been filed on April 15, 2002.

(f) *Claim for credit or refund on late filed tax return*—(1) *In general.* Generally, an original income tax return may constitute a claim for credit or refund of income tax. See § 301.6402–3(a)(5). Other original tax returns can also be considered claims for credit or refund if the liability disclosed on the return is less than the amount of tax that has been paid. If section 7502 would not apply to a return (but for the operation of paragraph (f)(2) of this section) that is also considered a claim for credit or refund because the envelope that contains the return does not have a postmark dated on or before the due date of the return, section 7502 will apply separately to the claim for credit or refund if—

(i) The date of the postmark on the envelope is within the period that is three years (plus the period of any extension of time to file) from the day the tax is paid or considered paid (see section 6513), and the claim for credit or refund is delivered after this three-year period; and

(ii) The conditions of section 7502 are otherwise met.

(2) *Filing date of late filed return.* If the conditions of paragraph (f)(1) of this section are met, the late filed return will be deemed filed on the postmark date.

(3) *Example.* The rules of this paragraph (f) are illustrated by the following example:

Example. (i) Taxpayer A, an individual, mailed his 2001 Form 1040, ''U.S. Individual Income Tax Return,'' on April 15, 2005, claiming a refund of amounts paid through withholding during 2001. The date of the postmark on the envelope containing the return and claim for refund is April 15, 2005. The return and claim for refund are received by the Internal Revenue Service (IRS) on April 18, 2005. Amounts withheld in 2001 exceeded A's tax liability for 2001 and are treated as paid on April 15, 2002, pursuant to section 6513.

(ii) Even though the date of the postmark on the envelope is after the due date of the return, the claim for refund and the late filed return are treated as filed on the postmark date for purposes of this paragraph (f). Accordingly, the return will be treated as filed on April 15, 2005. In addition, the claim for refund will be treated as timely filed on April 15, 2005. Further, the entire amount of the refund attributable to withholding is allowable as a refund under section 6511(b)(2)(A).

(g) *Effective date*—(1) *In general.* Except as provided in paragraphs (g)(2) and (3) of this section, the rules of this section apply to any payment or document mailed and delivered in accordance with the requirements of this section in an envelope bearing a postmark dated after January 11, 2001.

(2) *Claim for credit or refund on late filed tax return.* Paragraph (f) of this section applies to any claim for credit or refund on a late filed tax return described in paragraph (f)(1) of this section except for those claims for credit or refund which (without regard to paragraph (f) of this section) were barred by the operation of section 6532(a) or any other law or rule of law (including res judicata) as of January 11, 2001.

(3) *Electronically filed documents.* This section applies to any electronically filed return, claim, statement, or other document transmitted to an electronic return transmitter that is authorized to provide an electronic postmark pursuant to paragraph (d)(2) of this section after January 11, 2001.

§ 301.7502–1T [Removed]

Par. 3. Section 301.7502–1T is removed.

Par. 4. Section 301.7502–2 is added to read as follows:

§ 301.7502–2 Timely mailing of deposits.

(a) *General rule*—(1) *Two day rule.* Section 7502(e) provides that, if the requirements of that section are met, a deposit is deemed to be received on the date the deposit was mailed even though it is received after the date prescribed for making the deposit. The requirements of the section are met if the person required to make the deposit establishes that the date of mailing was on or before the second day preceding the date prescribed for making the deposit. If the date of mailing was not established to be on or before the second day preceding the date prescribed for making the deposit, the deposit will not be considered timely received unless it is actually received on or before the date prescribed for making the deposit. Section 7502(e) only applies to a deposit mailed to the financial institution authorized to receive that deposit. Thus, section 7502(e) does not apply to any remittance mailed to an internal revenue service center.

(2) *Deposits of $20,000 or more.* Paragraph (a)(1) of this section does not apply with respect to any deposit of $20,000 or more by any person required to deposit any tax more than once a month. Any such deposit must be made by the due date for such deposit, regardless of the method of delivery.

(b) *Deposit defined.* The term *deposit,* as used in this section, means any deposit of tax required to be made on or before a prescribed date at an authorized financial institution pursuant to regulations prescribed under section 6302.

(c) *Mailing requirements*—(1) *In general.* Section 7502(e) does not apply unless the deposit is mailed in accordance with the requirements of paragraph (c)(2) of this section.

(2) *Requirements.* The date of mailing must fall on or before the second day preceding the prescribed date for making a deposit (including any extension of time granted for making the deposit). For example, if a deposit is due on or before January 15, the date of mailing must fall on or before January 13. The deposit must be contained in an envelope or other appropriate wrapper approved for use in the mails by the U.S. Postal Service, properly addressed to the financial institution authorized to receive the deposit. The deposit must be deposited with sufficient postage prepaid in the mail in the United States within the meaning of § 301.7502–1 on or before the second day preceding the prescribed date for making a deposit.

(3) *Registered and certified mail.* The provisions of § 301.7502–1(c)(2) apply to a deposit sent by U.S. registered mail or U.S. certified mail as if the deposit were a payment, except that the date of registration or the date of the postmark on the sender's receipt is considered the date of mailing of such deposit.

(d) *Delivery.* Section 7502(e) does not apply unless a deposit is actually delivered by U.S. mail to the authorized financial institution with which the deposit is required to be made and is accepted by that financial institution. For rules relating to the acceptance of deposits by authorized financial institutions see 31 CFR 203.18. The fact that a deposit is sent by U.S. registered or U.S. certified mail does not constitute prima facie evidence that the deposit was delivered to the financial institution authorized to receive the deposit. Section 7502(e) does not apply unless the deposit is delivered after the date prescribed for making the deposit.

(e) *Effective date.* This section applies to all deposits required to be made after January 11, 2001.

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 21, 2000.

Jonathan Talisman,

Acting Assistant Secretary of the Treasury.

[FR Doc. 01–130 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[TD 8935]

RIN 1545–AY59

Disclosure of Returns and Return Information to Designee of Taxpayer

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Temporary regulation.

SUMMARY: This document contains a temporary regulation relating to the disclosure of returns and return information to a designee of the taxpayer. The temporary regulation provides guidance to IRS employees responsible for disclosing returns and return information and to taxpayers who wish to designate a person or persons to whom returns and return information may be disclosed. The portion of this temporary regulation pertaining to nonwritten requests or consents reflects changes to the law made by the Taxpayer Bill of Rights II, Public Law 104–168, section 1207, 110 Stat. 1473. With respect to written requests or consents, the temporary regulation amends the existing regulation to provide further guidance in certain limited situations and to clarify existing procedures. The text of the temporary regulation also serves as the text of the proposed regulation set forth in the notice of proposed rulemaking on this subject in the Proposed Rules section of this issue of the **Federal Register**.

DATES: *Effective Date:* This regulation is effective January 11, 2001.

Applicability Date: For dates of applicability, see § 301.6103(c)–1T(g).

FOR FURTHER INFORMATION CONTACT: Joseph Conley, (202) 622–4580 (not a toll-free number).

Background

Under section 6103(a), returns and return information are confidential unless disclosure is otherwise authorized by the Internal Revenue Code. Section 6103(c), as amended by section 1207 of the Taxpayer Bill of Rights II, Public Law 104–168 (110 Stat. 1452), authorizes the IRS to disclose returns and return information to such person or persons as the taxpayer may designate in a request for or consent to disclosure, or to any other person at the taxpayer's request to the extent necessary to comply with a request for information or assistance made by the taxpayer to such other person. Disclosure is permitted subject to such requirements and conditions as may be prescribed by regulations. With the amendment in 1996, Congress eliminated the longstanding requirement that disclosures to designees of the taxpayer must be pursuant to the written request or consent of the taxpayer. The purpose of this amendment to section 6103(c) was to assist the IRS in developing a paperless tax administration system that relies on, among other things, electronic communication. H.R. Rep. No. 104–506, at 49 (1996), reprinted in 1996 U.S.C.A.N. 1143, 1172. This document contains a temporary regulation that authorizes the disclosure of tax returns and return information to a designee of the taxpayer pursuant to a nonwritten request or consent when the taxpayer seeks the assistance of a third party in resolving a tax matter.

This document also amends the existing regulation to clarify the rules applicable to written requests or consents to disclosure. On October 3, 1980, a final regulation (TD 7723) relating to the disclosure of tax returns and return information to a person designated by the taxpayer in a written request or consent were published in the **Federal Register** (45 FR 65564). Since the publication of this final regulation, the IRS and the Treasury Department have determined that further guidance on written consent requirements is necessary.

Explanation of Provisions

Nonwritten consents

Under the existing regulation, if a taxpayer wishes a third party to assist in the resolution of a tax matter between the taxpayer and the IRS, and the third party is not otherwise authorized to practice before the Internal Revenue Service, a written section 6103(c) request or consent must be executed by the taxpayer.

The temporary regulation authorizes the IRS to accept nonwritten requests or consents authorizing the disclosure of tax returns and return information to third parties assisting taxpayers in resolving tax related matters. Thus, for example, the temporary regulation clarifies that the taxpayer can orally consent to disclosures by the IRS to a person accompanying the taxpayer to meetings or interviews with the IRS, or participating in a telephone conversation with the taxpayer. When the taxpayer is present, either physically or on the telephone, the taxpayer will be able to knowingly and voluntarily consent to the disclosure without the need for further expressing that intent in writing.

Thus, the use of nonwritten consents will enable the IRS to improve its customer service in that, with the assistance of their designees, taxpayers will be able to resolve tax problems in a more timely fashion, without the need for burdensome paperwork. Additionally, nonwritten requests or consents will assist the IRS in moving to a paperless environment by further facilitating the use of electronic communication systems.

As with written requests or consents, before disclosing tax returns and return information to a third party pursuant to a taxpayer's nonwritten request or consent, the IRS will take reasonable steps to confirm the identity of the taxpayer and the designee. For example, IRS personnel, pursuant to existing procedures, verify that they are speaking to the taxpayer prior to disclosing return information to that taxpayer.

Nonwritten requests for or consents to disclosure do not take the place of a power of attorney authorizing a third party to represent the taxpayer before the IRS. Practice before the IRS remains governed by the regulations at 26 CFR 601.501 *et seq.* and Treasury Department Circular 230 (31 CFR part 10).

Acknowledgments of, and Notices Regarding, Electronically Filed Returns

The temporary regulation also provides parameters for the development of consents for the electronic filing program. The IRS currently provides an acknowledgment to an electronic return originator (ERO) to indicate that it has received information from the ERO in an acceptable form, and that the taxpayer identity information, as defined by section 6103(b)(6), matches IRS records. Alternatively, the IRS may notify the ERO that it has rejected the ERO's electronic submission because the taxpayer identity information does not match IRS records or, for example, because the taxpayer is not responsible for the tax payment. The taxpayer may also have authorized an electronic debit to pay a tax debt, and the taxpayer may want the IRS to send an acknowledgment to the ERO that the account has been properly debited, or to disclose information to the taxpayer's financial institution to resolve a problem with the electronic debit transaction. To ensure that the IRS is authorized to disclose tax returns and return information to third parties in an electronic system, the IRS must receive a valid request for or consent to disclosure pursuant to section 6103(c). The current system requires the taxpayer to execute a written consent on Form 8453 to permit these disclosures.

The temporary regulation authorizes an electronic consent to permit the disclosures of the return information described above and such other information as the IRS determines is necessary to the operation of the electronic filing program. Such consent must inform the taxpayer of the return information that will be transmitted to the ERO and other third parties as a result of the electronic filing of the taxpayer's return or other information.

Combined FedState Filing Programs

The temporary regulation also reduces the burden on taxpayers in combined Federal-State (FedState) return filing programs. If the taxpayer files a single combined Federal and State tax return with the IRS, the information contained in such FedState return that is gathered with respect to a taxpayer's liability under both Federal and State law, including the taxpayer's name, taxpayer identification number, and adjusted gross income, is return information protected by section 6103. If the IRS discloses such return information to the State in satisfaction of the taxpayer's State filing obligations, the information can be used by the State only for State tax administration purposes under section 6103(d). On the other hand, if a State tax return is filed directly with the State, information on the State return is not subject to the restrictions of section 6103(d) and can be used for appropriate non-tax purposes permitted under State law.

In the current electronic FedState filing program, to avoid these section 6103 restrictions, return preparers make two separate electronic transmissions to the IRS—one for the Federal return and one for the State return. The common items of data are sent twice, once in the

Federal ''packet'' and once in the State ''packet.'' The items of information in the State packet are not restricted by section 6103 because they have not been filed with the IRS with regard to Federal tax liability.

Alternatively, in the FedState telefile program, a consent has been developed that permits the Internal Revenue Service to disclose common data items to the State tax agency. The information received by the State pursuant to the taxpayer's request or consent is treated, for purposes of section 6103, as if the State had received the information directly from the taxpayer, and therefore the information can be used for appropriate non-tax purposes under State law.

Under the existing regulation, consents for FedState filing programs must comply with current § 301.6103(c)–1(a). The existing regulation requires, among other things, a separate written consent document. The IRS and the Treasury Department believe a taxpayer's voluntary participation in an optional FedState filing program that provides the taxpayer with notice of the disclosures to be made to the State as part of the program constitutes a sufficient knowing and voluntary consent to permit disclosures to States in this situation. To reduce the burden on taxpayers and improve the efficiency of tax administration, the temporary regulation provides that by filing a combined FedState return, the taxpayer consents to the disclosure of the common data items to the State tax agency, and that the information will be treated as if it had been received directly by the State from the taxpayer. As noted above, the temporary regulation requires a notice of the disclosures that are to be made in the FedState filing program so that taxpayers may choose to participate in such programs with knowledge of such disclosures.

Other Changes

The temporary regulation also provides needed clarification in a number of areas not specifically addressed under the existing regulation. The temporary regulation provides rules for receipt of section 6103(c) consents by entities other than the IRS. Certain Treasury Department agencies, such as the Financial Management Service, perform Federal tax administration functions and receive tax information from the IRS. In addition, IRS contractors receive tax information to provide tax administration services pursuant to section 6103(n). The existing regulation provides only for receipt of requests for or consents to disclosure by the IRS. The temporary regulation permits Federal government agencies performing Federal tax administration functions to receive section 6103(c) consents and disclose returns and return information in the possession of such agency to the taxpayer's designee. For example, the temporary regulation clarifies that the Financial Management Service can disclose return information related to the offset of the taxpayer's tax refund to the designee of the taxpayer, such as in response to a Congressional inquiry. The temporary regulation also clarifies that receipt of a request or consent by an agent or contractor of the IRS is the same as receipt by the IRS. However, an agent or contractor of the IRS may make disclosures with the taxpayer's consent only if such disclosures are specifically authorized in the contract or otherwise specifically authorized in writing by the IRS. § 301.6103(n)–1(a).

The temporary regulation defines the term *separate written document* to conform to current IRS practice. The temporary regulation also specifies the Secretary of the Treasury's authority to provide for methods of signing requests for or consents to disclosure. See § 301.6061–1(b).

The temporary regulation clarifies the requirements for identifying the designee to whom disclosure is to be made when the disclosure occurs in a public forum, such as a courtroom, a congressional hearing, or in the media. In these circumstances, it may not be possible to designate specifically every person to whom disclosure is to be made. While identifying individual designees in a public forum may not be practical, a taxpayer can knowingly and voluntarily authorize disclosure in a public forum by specifically indicating the circumstances surrounding the public disclosure, including, for example, a description of the place, date, and time. The temporary regulation also incorporates the longstanding IRS practice that entities, such as corporations and State and local government agencies, are appropriate designees.

The temporary regulation also affirms longstanding practices of the IRS regarding the authority to execute consents. Generally, persons that may receive returns pursuant to section 6103(e), paragraphs (1) through (5), may execute disclosure consents under section 6103(c). However, a one percent shareholder of a corporation, who may receive corporate returns pursuant to section 6103(e)(1)(D)(iii), may not execute disclosure consents because the right of inspection is personal to the shareholder, and such shareholder is not permitted to redisclose such information. See Internal Revenue Code §§ 6103(a)(3), 7213(a)(5). The temporary regulation also provides that if the taxpayer is an entity, generally a person with authority under State law to bind the entity may execute a section 6103(c) consent. Finally, the temporary regulation provides that the holder of a taxpayer's power of attorney may not execute a disclosure consent unless that authority is specifically granted in the power.

Special Analyses

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. This temporary regulation provides taxpayers with enhanced procedures to resolve problems with the IRS. For this reason, notice and public procedure and a delayed effective date would be contrary to the public interest pursuant to 5 U.S.C. 553(b)(B) and 553(d), respectively. Because this notice of proposed rulemaking is required, the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) do not apply. Pursuant to section 7805(f) of the Internal Revenue Code, this temporary regulation will be submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of this regulation is Jamie Bernstein, Office of the Associate Chief Counsel, Procedure and Administration (Disclosure & Privacy Law Division). However, other personnel from the IRS and Treasury Department participated in its development.

List of Subjects in 26 CFR Part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 301 is amended as follows:

PART 301—PROCEDURE AND ADMINISTRATION

Paragraph 1. The authority citation for part 301 is amended by adding an entry in numerical order to read as follows:

Authority: 26 U.S.C. 7805 * * *

Section 301.6103(c)–1 also issued under 26 U.S.C. 6103(c). * * *

§ 301.6103(c)–1 [Removed]

Par. 2. Section 301.6103(c)–1 is removed.

Par. 3. Section 301.6103(c)–1T is added to read as follows:

§ 301.6103(c)–1T Disclosure of returns and return information to designee of taxpayer.

(a) *Overview.* Subject to such requirements and conditions as the Secretary of the Treasury may prescribe by regulation, section 6103(c) of the Internal Revenue Code authorizes the Internal Revenue Service to disclose a taxpayer's return or return information to such person or persons as the taxpayer may designate in a request for or consent to such disclosure, or to any other person at the taxpayer's request to the extent necessary to comply with the taxpayer's request to such other person for information or assistance. This regulation contains the requirements that must be met before, and the conditions under which, the Internal Revenue Service may make such disclosures. Paragraph (b) of this section provides the requirements that are generally applicable to designate a third party to receive the taxpayer's returns and return information. Paragraph (c) of this section provides requirements under which the Internal Revenue Service may disclose information in connection with a taxpayer's written or nonwritten request for a third party to provide information or assistance with regard to a tax matter, for example, a Congressional inquiry. Paragraph (d) of this section provides the parameters for disclosure consents connected with electronic return filing programs and combined Federal State filing. Finally, paragraph (e) provides definitions and general rules related to requests for or consents to disclosure.

(b) *Disclosure of returns and return information to person or persons designated in a written request or consent*—(1) *General requirements.* Pursuant to section 6103(c) of the Internal Revenue Code, the Internal Revenue Service (or an agent or contractor of the Internal Revenue Service) may disclose a taxpayer's return or return information to such person or persons as the taxpayer may designate in a request for or consent to such disclosure. A request for or consent to disclosure under this paragraph (b) must be in the form of a separate written document pertaining solely to the authorized disclosure. (For the meaning of separate written document, see paragraph (e)(1) of this section.) The separate written document must be signed (see paragraph (e)(2) of this section) and dated by the taxpayer who filed the return or to whom the return information relates. The taxpayer must also indicate in the written document—

(i) The taxpayer's taxpayer identity information described in section 6103(b)(6);

(ii) The identity of the person or persons to whom the disclosure is to be made;

(iii) The type of return (or specified portion of the return) or return information (and the particular data) that is to be disclosed; and

(iv) The taxable year or years covered by the return or return information.

(2) *Requirement that request or consent be received within sixty days of when signed and dated.* The disclosure of a return or return information authorized by a written request for or written consent to the disclosure shall not be made unless the request or consent is received by the Internal Revenue Service (or an agent or contractor of the Internal Revenue Service) within 60 days following the date upon which the request or consent was signed and dated by the taxpayer.

(c) *Disclosure of returns and return information to designee of taxpayer to comply with a taxpayer's request for information or assistance.* Where a taxpayer makes a written or nonwritten request, directly to another person or to the Internal Revenue Service, that such other person (for example, a member of Congress, friend, or relative of the taxpayer) provide information or assistance relating to the taxpayer's return or to a transaction or other contact between the taxpayer and the Internal Revenue Service, the Internal Revenue Service (or an agent or contractor of the Internal Revenue Service or a Federal government agency performing a Federal tax administration function) may disclose returns or return information to such other person under the circumstances set forth in paragraphs (c) (1) through (3) of this section.

(1) *Written request for information or assistance.* (i) The taxpayer's request for information or assistance may be in the form of a letter or other written document, which must be signed (see paragraph (e)(2) of this section) and dated by the taxpayer. The taxpayer must also indicate in the written request—

(A) The taxpayer's taxpayer identity information described in section 6103(b)(6);

(B) The identity of the person or persons to whom disclosure is to be made; and

(C) Sufficient facts underlying the request for information or assistance to enable the Internal Revenue Service to determine the nature and extent of the information or assistance requested and the returns or return information to be disclosed in order to comply with the taxpayer's request.

(ii) A person who receives a copy of a taxpayer's written request for information or assistance but who is not the addressee of the request, such as a member of Congress who is provided with a courtesy copy of a taxpayer's letter to another member of Congress or to the Internal Revenue Service, cannot receive returns or return information under paragraph (c)(1) of this section.

(2) *Nonwritten request or consent.* (i) A request for information or assistance may also be nonwritten. Disclosure of returns and return information to a designee pursuant to a taxpayer's nonwritten request will be made only after the Internal Revenue Service has—

(A) Obtained from the taxpayer sufficient facts underlying the request for information or assistance to enable the Internal Revenue Service to determine the nature and extent of the information or assistance requested and the return or return information to be disclosed in order to comply with the taxpayer's request;

(B) Confirmed the identity of the taxpayer and the designee; and

(C) Confirmed the date, the nature, and the extent of the information or assistance requested.

(ii) Examples of disclosures pursuant to nonwritten requests for information or assistance under this paragraph (c)(2) include, but are not limited to, disclosures to a friend, relative, or other person whom the taxpayer brings to an interview or meeting with Internal Revenue Service officials, or disclosures to a person whom the taxpayer wishes to involve in a telephone conversation with Internal Revenue Service officials.

(3) *Rules applicable to written and nonwritten requests for information or assistance.* A return or return information will be disclosed to the taxpayer's designee as provided by this paragraph only to the extent considered necessary by the Internal Revenue Service to comply with the taxpayer's request or consent. Such disclosures shall not be made unless the request or consent is received by the Internal Revenue Service, its agent or contractor, or a Federal government agency performing a Federal tax administration function in connection with a request for advice or assistance relating to such function. This paragraph (c) does not apply to disclosures to a taxpayer's representative in connection with

practice before the Internal Revenue Service (as defined in Treasury Department Circular No. 230). For disclosures in these cases, see section 6103(e)(6) and §§ 601.501 through 601.508 of this chapter.

(d) *Acknowledgments of electronically filed returns and other documents; combined filing programs with State tax agencies—(1) Acknowledgment of, and notices regarding, electronically filed returns and other documents.* When a taxpayer files returns or other documents or information with the Internal Revenue Service electronically, the taxpayer may consent to the disclosure of return information to the transmitter or other third party, such as the taxpayer's financial institution, necessary to acknowledge that the electronic transmission was received and either accepted or rejected by the Internal Revenue Service, the reason for any rejection, and such other information as the Internal Revenue Service determines is necessary to the operation of the electronic filing program. The consent must inform the taxpayer of the return information that will be transmitted and to whom disclosure will be made. The requirements of paragraphs (b) and (c) of this section do not apply to a consent under this paragraph (d)(1).

(2) *Combined return filing programs with State tax agencies.* (i) A taxpayer's participation in a combined return filing program between the Internal Revenue Service and a State agency, body, or commission (State agency) described in section 6103(d)(1) constitutes a consent to the disclosure by the Internal Revenue Service, to the State agency, of taxpayer identity information, signature, and items of common data contained on such return. For purposes of this paragraph, common data means information reflected on the Federal return required by State law to be attached to or included on the State return. Instructions accompanying the forms or published procedures involved in such program must indicate that by participating in the program, the taxpayer is consenting to the Internal Revenue Service's disclosure to the State agency of the taxpayer identity information, signature, and items of common data, and that such information will be treated by the State agency as if it had been directly filed with the State agency. Such instructions or procedures must also describe any verification that takes place before the taxpayer identity information, signature and common data is transmitted by the Internal Revenue Service to the State agency.

(ii) No disclosures may be made under this paragraph (d)(2) unless there are provisions of State law protecting the confidentiality of such items of common data.

(e) *Definitions and rules applicable to this section—(1) Separate written document.* (i) For the purposes of paragraph (b) of this section, *separate written document* means—

(A) One side of a standard (8½″ by 11″ or larger) sheet of paper, which may be included as part of a larger document;

(B) Text appearing on a single computer screen containing all the elements described in paragraph (b)(1) of this section, which can be signed (see paragraph (e)(2) of this section) and dated by the taxpayer, and which can be reproduced, if necessary; or

(C) A consent on the record in an administrative or judicial proceeding, or a transcript of such proceeding recording such consent, containing the information required under paragraph (b)(1) of this section.

(ii) A provision included in a taxpayer's application for a loan or other benefit authorizing the grantor of the loan or other benefit to obtain any financial information, including returns or return information, from any source as the grantor may request for purposes of verifying information supplied on the application, does not meet the requirements of paragraph (b)(1) of this section because the provision is not a separate written document relating solely to the disclosure of returns and return information. In addition, the provision does not contain the other information specified in paragraph (b)(1) of this section.

(2) *Method of signing.* A request for or consent to disclosure may be signed by any method of signing the Secretary of the Treasury has prescribed pursuant to § 301.6061–1(b) in forms, instructions, or other appropriate guidance.

(3) *Permissible designees and public forums.* Permissible designees under this section include individuals; trusts; estates; corporations; partnerships; Federal, State, local and foreign government agencies or subunits of such agencies; or the general public. When disclosures are to be made in a public forum, such as in a courtroom or congressional hearing, the request for or consent to disclosure must describe the circumstances surrounding the public disclosure, e.g., congressional hearing, judicial proceeding, media, and the date or dates of the disclosure.

(4) *Authority to execute a request for or consent to disclosure.* Any person who may obtain returns under section 6103(e)(1) through (5), except section 6103(e)(1)(D)(iii), may execute a request for or consent to disclose a return or return information to third parties. For taxpayers that are legal entities, such as corporations and municipal bond issuers, any officer of the entity with authority under applicable State law to legally bind the entity may execute a request for or consent to disclosure. A person described in section 6103(e)(6) (a taxpayer's representative or individual holding a power of attorney) may not execute a request for or consent to disclosure unless the designation of representation or power of attorney specifically delegates such authority. A designee pursuant to this section does not have authority to execute a request for or consent to disclosure permitting the Internal Revenue Service to disclose returns or return information to another person.

(5) *No disclosure of return information if impairment.* A disclosure of return information shall not be made under this section if the Internal Revenue Service determines that the disclosure would seriously impair Federal tax administration (as defined in section 6103(b)(4) of the Internal Revenue Code).

(f) *Effective date.* This section is applicable on January 11, 2001 through January 12, 2004.

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

Approved: December 29, 2000.

Jonathan Talisman

Assistant Secretary of the Treasury.

[FR Doc. 01–485 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1956

RIN 1218–AB98

Notice of Initial Approval Determination; New Jersey Public Employee Only State Plan

AGENCY: Occupational Safety and Health Administration, Department of Labor (OSHA).

ACTION: Final Rule: Initial State Plan Approval; New Jersey Public Employee Only State Plan.

SUMMARY: The New Jersey Public Employee Only State plan, a State occupational safety and health plan applicable only to public sector employees (employees of the State and its political subdivisions), is approved

as a developmental plan under section 18 of the Occupational Safety and Health Act of 1970 and 29 CFR part 1956. Under the approved plan, the New Jersey Department of Labor is designated as the State agency responsible for the development and enforcement of occupational safety and health standards applicable to public employment throughout the State. The Occupational Safety and Health Administration (OSHA) retains full authority for coverage of private sector employees in the State of New Jersey as well as for coverage of Federal government employees.

EFFECTIVE DATE: January 11, 2001.

FOR FURTHER INFORMATION CONTACT: Paula O. White, Director, Federal-State Operations, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3700, 200 Constitution Avenue, NW., Washington, DC 20210. Telephone: (202) 693–2200, Fax: (202) 693–1671, E-mail: *Paula.White@osha.gov.*

SUPPLEMENTARY INFORMATION:

A. Introduction

Section 18 of the Occupational Safety and Health Act of 1970 (the ''OSH Act''), 29 U.S.C. 667, provides that a State which desires to assume responsibility for the development and enforcement of occupational safety and health standards relating to any occupational safety and health issue with respect to which a Federal standard has been promulgated may submit a State plan to the Assistant Secretary of Labor for Occupational Safety and Health (''Assistant Secretary'') documenting in detail the proposed program. Regulations promulgated pursuant to the OSH Act at 29 CFR part 1956 provide that a State may submit a State plan for the development and enforcement of standards applicable only to employees of the State and its political subdivisions (''public employees''). State and local government workers are excluded from Federal coverage under the OSH Act and are provided protection only through the vehicle of a State Plan approved pursuant to Section 18 of the Act.

Under these regulations, the Assistant Secretary will approve a State plan for public employees if the plan provides for the development and enforcement of standards relating to hazards in employment covered by the plan which are, or will be, at least as effective in providing safe and healthful employment and places of employment for public employees as standards promulgated and enforced under section 6 of the OSH Act, giving due consideration to differences between public and private sector employment. In making this determination the Assistant Secretary will consider, among other things, the criteria and indices of effectiveness set forth in 29 CFR Part 1956, Subpart B. A State plan for public employees may receive initial approval even though, upon submission, it does not fully meet the criteria set forth in §§ 1956.10 and 1956.11, if it includes satisfactory assurances by the State that it will take the necessary steps, and establishes an acceptable developmental schedule, to meet the criteria within a 3-year period (29 CFR 1956.2(b)). The Assistant Secretary publishes a notice of ''certification of completion of developmental steps'' when all of a State's developmental commitments have been met satisfactorily (29 CFR 1956.23; 1902.33 and 1902.34) and the plan is structurally complete. After certification of a State plan for public employees, OSHA may initiate a period of at least one year of intensive monitoring, after which OSHA may make a determination under the procedures of §§ 1902.38, 1902.39, 1902.40 and 1902.41 as to whether, on the basis of actual operations, the criteria set forth in §§ 1956.10 and 1956.11 for ''at least as effective'' State plan performance are being applied under the plan—a determination of ''operational effectiveness.''

B. History of the Present Proceeding

In 1973, the New Jersey Department of Labor and Industry obtained OSHA approval of a State plan for the enforcement of occupational safety and health standards covering private sector workplaces as well as a program for public employees in New Jersey. That plan was approved by the Assistant Secretary on January 22, 1973 ((37 FR 2426); 29 CFR 1952.140 et seq). That plan was subsequently withdrawn by the State of New Jersey effective June 30, 1975, after the State was unable to gain enactment of the necessary State OSHA legislation (40 FR 27655).

In 1984, the New Jersey State Legislature passed the New Jersey Public Employees Occupational Safety and Health (PEOSH) Act, N.J.S.A. 34:6A (the ''State Act''), which was signed into law by the Governor, and which provided the basis for establishing a comprehensive occupational safety and health program applicable to the public employees in the State.

The State formally submitted for Federal approval a plan applicable only to public employees in February 1988. OSHA's review findings were detailed in an October 1988 letter to the State in which OSHA determined that the New Jersey statute, as then structured, and the proposed State plan failed to meet Federal Public Employee Only State plan approval criteria.

A revised plan was submitted by the State on February 19, 1992. On March 27, 1992, OSHA informed the State of its findings, identifying areas of the proposed plan which needed to be addressed or needed clarification. Amended enabling legislation was signed into law on July 25, 1995, to conform the proposed State plan to OSHA requirements. On October 11, 1995, the New Jersey State Labor Commissioner submitted a newly revised State plan which OSHA determined was conceptually approvable as a developmental State plan, but which could not be approved until additional Federal matching grant funds, necessary for approval of a new State plan, were appropriated under section 23(g) of the OSH Act. (The OSH Act provides for funding ''up to 50%'' of the State plan costs, but longstanding language in OSHA's appropriation legislation further provides that OSHA must fund ''* * * no less than 50% of the costs required to be incurred'' by an approved State plan. Thus Federal matching grant funds must be available before a State plan can be approved.)

On August 1, 2000, current New Jersey Commissioner of Labor, Mark B. Boyd, and Commissioner of Health and Senior Services, Christine Grant, submitted a further revised plan document, with subsequent amendments submitted on August 15, August 29, September 1, September 22, September 28, and October 5, 2000. On December 21, 2000, the President signed the appropriation act for FY 2001 for the Department of Labor, as approved by the Congress, which includes funding for the Occupational Safety and Health Administration specifically designated for initial approval of the New Jersey State plan.

On November 13, 2000, OSHA published notice in the **Federal Register** (65 FR 67672) concerning the submission of the New Jersey Public Employee Only State plan, announcing that initial Federal approval of the plan was at issue, and offering interested parties an opportunity to review the plan and submit data, views, arguments or requests for a hearing concerning the plan. The New Jersey Department of Labor published similar notices throughout the State from November 15–17, 2000, in the following New Jersey newspapers: *The Newark Star-Ledger, The South Jersey Courier-Post,*

The Trenton Times, The Atlantic City Press, and *The Bergen Record.* (Ex. #5)

To assist and encourage public participation in the initial approval process, copies of the New Jersey State plan were maintained as Docket No. T–034 in the Docket Office, Department of Labor, Occupational Safety and Health Administration, Third Street and Constitution Avenue, NW, Room N–2625, Washington, DC 20210; Office of the New York Regional Administrator, U.S. Department of Labor, Occupational Safety and Health Administration, 201 Varick Street, Room 670, New York, New York 10014; and the New Jersey Department of Labor, Division of Public Safety and Occupational Safety and Health, Office of Public Employees' Safety, P.O. Box 386, 225 East State Street, 8th Floor West, Trenton, New Jersey 08625–0386.

C. Summary and Evaluation of Comments Received

In response to OSHA's November 13, 2000, **Federal Register** notice, which announced submission of the New Jersey State plan and its availability for public comment, three (3) written public comments were submitted by: (1) Peter P. Guzzo, Executive Director/Legislative Agent, for Consumers for Civil Justice (OSHA Docket #T–034, Exhibit 3–1.); (2) Rick Engler, Director, New Jersey Work Environment Council, cosigned by the following 15 organizations: Harold Schaitberger, General President, for International Association of Fire Fighters, AFL–CIO; Thomas Canzanella, President, for Professional Firefighters Association of New Jersey, IAFF; William J. Lavin, for New Jersey Firemen's Mutual Benevolent Association; Michael Johnson, President, for New Jersey Education Association; David Legrande, Director of Occupational Safety and Health, for Communications Workers of America (CWA), AFL–CIO; Robert Pursell, New Jersey Area Director, for CWA District 1; Carla Katz, President, for CWA Local 1034; Michael Lohman, Staff Representative, for CWA, Local 1033, and Chairman, CWA New Jersey State Worker Locals Health and Safety Coordinating Committee; Bill Borwegan, Director of Occupational Safety and Health, for Service Employees International Union, AFL–CIO; Daryl Alexander, Associate Director for Occupational Safety and Health, for American Federation of Teachers (AFT), AFL–CIO; Nicholas C. Yovnello, President, for Council of New Jersey State College Locals, AFT; Ken Carlson, President for Rutgers Council of American Association of University Professors; Gerald Newsome, Trustee, for International Federation of Professional and Technical Engineers Local, 195, AFL–CIO; Edward II Lennon, President, for State Troopers Fraternal Association of New Jersey; Mark Dudzie, President, for Paper, Allied-Industrial, Chemical, and Energy Workers Local 2–149, AFL–CIO (OSHA Docket # T–034, Exhibit 3–2.); and; (3) Verri Andrea, student, University of Wisconsin-Madison. (OSHA Docket # T–034, Exhibit #4–1.)

All of the commenters listed above indicated their support for OSHA approval of the New Jersey Public Employee Only State plan. None has requested a public hearing or raised any issues for consideration.

D. Review Findings

As required by 29 CFR 1956.2 in considering the granting of initial approval to a State public employee only plan, OSHA must determine whether the State plan meets or will meet the criteria in 29 CFR 1956.10 and the indices of effectiveness in 29 CFR 1956.11. Findings and conclusions in each of the major State plan areas addressed by 29 CFR part 1956 are as follows:

(1) Designated Agency

Section 18(c)(1) of the OSH Act provides that a State occupational safety and health plan must designate a State agency or agencies responsible for administering the plan throughout the State (29 CFR 1956.10(b)(1)). The plan must describe the authority and responsibilities of the designated agency and provide assurance that other responsibilities of the agency will not detract from its responsibilities under the plan (29 CFR 1956.10(b)(2)). The New Jersey Department of Labor is designated by revised N. J. S. A. 34:6A–25 *et seq.*, as the sole agency responsible for administering and enforcing the New Jersey Public Employee Occupational Safety and Health (PEOSH) plan. (New Jersey State plan, p. 15.) The plan also describes the authority of the New Jersey Department of Labor and its other responsibilities. (New Jersey State plan, pp.16–16.2.) The New Jersey Department of Health and Senior Services has responsibility for conducting inspections with regard to occupational health hazards but all standards adoption and enforcement authority rests with the New Jersey Department of Labor. (N.J.S.A. 34:6A–30(e))

(2) Scope

Section 18(c)(6) of the OSH Act provides that the State, to the extent permitted by its law, shall under its plan establish and maintain an effective and comprehensive occupational safety and health program applicable to all employees of the State and its political subdivisions. Only where a State is constitutionally precluded from regulating occupational safety and health conditions in certain political subdivisions may the State exclude such political subdivision employees from coverage (29 CFR 1956.2(c)(1)). Further, the State may not exclude any occupational, industrial or hazard grouping from coverage under its plan unless OSHA finds that the State has shown there is no necessity for such coverage (29 CFR 1956.2(c)(2)).

The scope of the New Jersey State plan includes any employee of the State and any political subdivision thereof, including a public authority or any other governmental agency or authority. No employees of any political subdivision of the State or local government are excluded from the plan. (New Jersey State plan, pp 10–11.) The New Jersey Department of Labor adopts all Federal OSHA occupational safety and health standards, and the plan excludes no occupational, industrial or hazard grouping. (New Jersey State plan, p. 10)

Consequently, OSHA finds that the New Jersey plan contains satisfactory assurances that no employees of the State and its political subdivisions are excluded from coverage, and the plan excludes no occupational, industrial or hazard grouping.

(3) Standards

Section 18(c)(2) of the OSH Act requires State plans to provide for occupational safety and health standards which are at least as effective as Federal OSHA standards. A State plan for public employees must therefore provide for the development or adoption of such standards and must contain assurances that the State will continue to develop or adopt such standards (29 CFR 1956.10(c); 1956.11(b)(2)(ii)). A State may establish the same standards as Federal OSHA (29 CFR 1956.11(a)(1)), or alternative standards that are at least as effective as those of Federal OSHA (29 CFR 1956.11(a)(2)). Where a State's standards are not identical to Federal OSHA, they must meet the following criteria: they must be promulgated through a procedure allowing for consideration of all pertinent factual information and participation of all interested persons (29 CFR 1956.11(b) (2)(iii)); must, where dealing with toxic materials or harmful physical agents, assure employee protection throughout his or her working life (29 CFR 1956. 11(b)(2)(i));

must provide for furnishing employees appropriate information regarding hazards in the workplace through labels, posting, medical examinations, etc. (29 CFR 1956.11(b)(2)(vi)); and, must require suitable protective equipment, technological control, monitoring, etc. (29 CFR 1956.11(b)(2)(vii)).

In addition, the State plan must provide for prompt and effective standards setting actions for protection of employees against new and unforeseen hazards, by such means as authority to promulgate emergency temporary standards (29 CFR 1956.11(b)(2)(v)).

The PEOSH Act, 34:6A–30 *et seq.*, mandates that the Commissioner of Labor (the ''Commissioner'') shall adopt all safety and health standards promulgated under the OSH Act which are in effect on the effective date of the State Act (January 17, 1984, as amended July 25, 1995), and incorporate future revisions. (New Jersey State plan, p.19) The procedures for State adoption of Federal occupational safety and health standards include publication in the New Jersey Register in accordance with N.J.S.A. 52:14B–5. New Jersey has adopted State standards identical to Federal occupational safety and health standards promulgated as of December 7, 1998, with the exception of the hazard communication and fire protection standards. The State plan includes a commitment to bring those standards into conformance with OSHA requirements and to update all standards within one year after plan approval. (The State intends to incorporate appropriate provisions of the New Jersey Right to Know Act into its public sector occupational hazard communication standard.) The State plan also provides that future OSHA standards and revisions will be adopted by the State in accordance with 29 CFR 1953.21.

Under the New Jersey State plan, the Commissioner of Labor, in consultation with the Commissioner of Health and Senior Services, and the Commissioner of Community Affairs, and with the advice of the Public Employees' Safety and Health Advisory Board may adopt alternative or different occupational safety and health standards where no federal standards are applicable or where more stringent standards are deemed advisable. (N.J.S.A. 34:6A–30(c); New Jersey State plan, pp.21–28). Such standards will be adopted in accordance with the State Act and the New Jersey Administrative Procedures Act, N.J.S.A. 52–148–1 *et seq.*, which include provisions for interested persons to petition the State for a new or revised standard and which give interested persons the opportunity to participate in any hearing for the development, modification or establishment of standards.

Section 34:6A–30(b) of the amended State Act provides for coordination of the provisions of the State uniform construction code and the uniform fire safety code with State occupational safety and health standards. The Commissioner of Community Affairs is charged with amending the uniform construction or fire codes to reflect any more stringent applicable provisions of the State OSHA standards and with preparing an application to the Assistant Secretary for approval of any equally effective provision of the uniform construction or fire codes for incorporation into the State plan. In response to OSHA's concerns that building or fire codes may not appropriately address employee protection, New Jersey amended its State Act and provided assurance that Federal approval will be obtained prior to the incorporation of building or fire codes as State occupational safety and health standards into the State plan. (New Jersey State plan, p.27)

The New Jersey State plan also provides for the adoption of Federal emergency temporary standards within 30 days of Federal promulgation. State regulations will be amended to reflect this. (New Jersey State plan, p. 27)

Based on the foregoing plan provisions and assurances and commitments, OSHA finds the New Jersey State plan to have met the statutory and regulatory requirements for initial plan approval with respect to occupational safety and health standards.

(4) Variances

A State plan must provide authority for the granting of variances from State standards upon application of a public employer or employers which corresponds to variances authorized under the OSH Act, and for consideration of the views of interested parties, by such means as giving affected employees notice of each application and an opportunity to request and participate in hearings or other appropriate proceedings relating to applications for variances (29 CFR 1956.11(b)(2)(iv)).

The State Act provides for the granting of permanent and temporary variances from State standards (N.J.S.A., Section 34:6A–39; New Jersey State Plan, pp. 35–51) in terms substantially similar to the variance provisions of the OSH Act. The State provisions require employee notification of variance applications as well as employee rights to participate in hearings held on variance applications. Variances may not be granted unless it is established that adequate protection is afforded employees under the terms of the variance. However, the State's variance procedures at N.J.A.C. 12:110–6.5(c) require revision. The State has provided assurance in its developmental schedule that within two years of initial plan approval it will amend its regulations to reflect variance provisions contained in the Federal 29 CFR Part 1905. (New Jersey State Plan p. 38.)

Accordingly, OSHA finds that the New Jersey State plan effectively provides or will provide opportunity and procedures for variances from its occupational safety and health standards.

(5) Enforcement

Section 18(c)(2) of the OSH Act and 29 CFR 1956.10(d)(1) require a State plan to include provisions for enforcement of State standards which are or will be at least as effective in providing safe and healthful employment and places of employment as the Federal program, and to assure that the State's enforcement program for public employees will continue to be at least as effective as the Federal program in the private sector.

(a) *Legal Authority.* The State must require public employer and employee compliance with all applicable standards, rules and orders (29 CFR 1956.10(d)(2)) and must have the legal authority for standards enforcement (section 18(c)(4)) including compulsory process (29 CFR 1956.11(c)(2)(viii)).

Section 34:6A–33 of the State Act requires public employers to comply with the New Jersey Department of Labor's occupational safety and health standards; section 34:6A–34 requires employees to comply with all standards and regulations applicable to their own actions and conduct. Section 34:6A–31 of the revised State Act also provides that space leased by a public employer must be in conformance with current occupational safety and health requirements at the time a lease is executed.

(b) *Inspections.* A State plan must provide for inspection of covered workplaces, including in response to complaints, where there are reasonable grounds to believe a hazard exists (29 CFR 1956.11(c)(2)(i)).

When no compliance action results from inspection of violations alleged by employee complaints, the State must notify the complainant of its decision not to take compliance action by such means as written notification and

opportunity for informal review (29 CFR 1956.11(c)(2)(iii)).

The State Act provides for inspections of covered workplaces including inspections in response to employee complaints by the Commissioner of Labor, and with regard to health hazards, by the Commissioner of Health and Senior Services (N.J.S.A., Sections 34:6A–35, 36, and 38.) The New Jersey State plan (Section 1, pp. 73–75) provides that when a determination has been made that a complaint does not warrant an inspection, the complainant shall be notified in writing of the determination and given an opportunity to request a review of that determination. In response to OSHA comments, New Jersey revised its regulations and procedures to allow complainants to elect anonymity in the process.

(c) *Employee Notice and Participation in Inspection.* In conducting inspections, the State plan must provide an opportunity for employees and their representatives to point out possible violations through such means as employee accompaniment or interviews with employees (29 CFR 1956.11(c)(2)(ii)).

The State Act provides the opportunity for an employer and employee representative to accompany a Department of Labor or Department of Health and Senior Services inspector for the purpose of aiding in the inspection. (N.J.S.A., Section 34:6A–36 and –38.) Where there is no authorized employee representative, the inspectors are required to consult with a reasonable number of employees concerning matters of safety and health in the workplace. Any employee who accompanies an inspector representing either Commissioner on an inspection shall receive payment of normal wages for the time spent on the inspection. (N.J.S.A. Sec 34:6A–35,–36, –38)

In addition, the State plan must provide that employees be informed of their protections and obligations under the Act by such means as the posting of notices (29 CFR 1956.11(c)(2)(iv)); and provide that employees have access to information on their exposure to regulated agents and access to records of the monitoring of their exposure to such agents (29 CFR 1956.11(c)(2)(vi)).

The State Act provides that the Commissioner of Labor must issue regulations requiring that employers, through posting of notices, training or other appropriate means, keep their employees informed of their protections. (N.J.S.A., Section 34:6A–31.) A poster, which outlines employee protections and obligations under the Act, has been designed and distributed to public employers. Specific regulations as well as the poster have been submitted by the State. (New Jersey State Plan, Attachments 3 and 9.)

Information on employee exposure to regulated agents (in the public sector), access to medical and exposure records, and provision and use of suitable protective equipment is provided through State standards. New Jersey has adopted all Federal standards as of December 7, 1998 with the exception of 29 CFR part 1910, subpart L—Fire protection, and 29 CFR 1910.1200 Hazard Communication. The State plan contains an assurance that the State intends to adopt all applicable Federal standards either identically or submit alternative standards which are at least as effect as the Federal standards within one year of plan approval as a part of the 3-year developmental schedule. (New Jersey State Plan, pp. 28–32)

(d) *Nondiscrimination.* A State is expected to provide appropriate protection to employees against discharge or discrimination for exercising their rights under the State's program, including provision for employer sanctions and employee confidentiality (29 CFR 1956.11(c)(2)(v)).

The State Act provides that no person shall discharge, or otherwise discipline, or in any manner discriminate against any employee because such employee has filed a complaint or instituted or caused to be instituted any proceeding under or related to this section or has testified or is about to testify in any such proceeding, or because of the exercise by such employee on behalf of the employee or others of any right under this section. (N.J.S.A., Section 34:6A–45.)

The State Act provides that an employee who believes that he or she has been discharged, disciplined or otherwise discriminated against by any person in violation of this section, may within 180 days after the employee first has knowledge such a violation did occur, file a complaint with the Commissioner of Labor alleging that discrimination. (N.J.S.A., Section 34:6A–45b.) The Commissioner shall investigate such complaints as appropriate and make a determination within 90 days which shall include an order for all appropriate relief. The monetary penalty established for repeated violations may also be applied to repeated discriminatory acts. (N.J.S.A. 34:6A–41(d))

New Jersey will amend its regulations on nondiscrimination procedures, N.J.A.C. 12:110–7, to conform with Federal guidelines within two years after plan approval. (New Jersey State Plan, p. 80; Attachment 3.)

e. *Restraint of Imminent Danger.* A State plan is required to provide for the prompt restraint of imminent danger situations (29 CFR 1956.11(c)(2)(vii)).

Section 34:6A.44 of the State Act provides that the Attorney General, at the request of and on behalf of the Commissioner of Labor, may bring an action in the Superior Court to restrain any conditions or practices in any workplace which the Commissioner determines, in accordance with the State Act (N.J.S.A. 34:6A–41), are such that a danger exists which could reasonably be expected to cause death or serious physical harm immediately or before the danger could be eliminated through the enforcement process. (New Jersey State plan, pp. 66–69.)

(f) *Right of Entry; Advance Notice.* A State program is required to have authority for right of entry to inspect and compulsory process to enforce such right equivalent to the Federal program (section 18(c)(3) of the Act and 29 CFR 1956.10(e)). Likewise, a State is expected to prohibit advance notice of inspection, allowing exception thereto no broader than in the Federal program (29 CFR 1956.10(f)).

The State Act provides that the Commissioner of Labor and the Commissioner of Health and Senior Services both have the right of immediate entry of any premises occupied by a public employer at reasonable hours, and without advance notice if there is reason to believe that a violation of this section of State law has occurred. (N.J.S.A., 34:3A–35.)

The New Jersey State plan (p.63–64) describes its general policy and procedures prohibiting advance notice of inspections and allowing exception thereto. Any person who gives advance notice of any inspection to be conducted under this act, without authority from the Commissioner of Labor or the Commissioner of Health and Senior Services or their designees, shall upon conviction, be punished by a fine of not more than $1,000 or by imprisonment for not more than six (6) months, or by both. (N.J.S.A. 34:6A–35(g)).

(g) *Citations, Sanctions, and Abatement.* A State plan is expected to have authority and procedures for promptly notifying employers and employees of violations, including proposed abatement requirements, identified during inspection, for the proposal of effective first-instance sanctions against employers found in violation of standards, and for prompt employer notification of any such sanctions. In lieu of monetary penalties as a sanction, a complex of enforcement

tools and rights, including administrative orders and employee right to contest citations (as well as abatement dates), may be demonstrated to be as effective as monetary penalties in achieving compliance in public employment (29 CFR 1956.11(c)(2)(ix) and (x)).

The State Act describes the authority and general procedures of the Commissioner of Labor to promptly notify public employers and employees of violations, and abatement requirements and to compel compliance therewith. The Commissioner of Labor must issue a written order to comply with reasonable promptness which is in no case no more than six months after determination of the existence of a safety violation or certification from the Commissioner of Health and Senior Services of a health violation. (N.J.S.A., Section 34:6A–35 and –41.)

The New Jersey State plan (pp. 87–90) provides that when an inspection of an establishment has been made, and the Commissioner of Labor has issued an order to comply, the employer shall post such order or a copy thereof at or near each location of the violation cited in the order so that it is clearly visible to affected employees. The Commissioner must make such order available to employee representatives, affected employees and the public. A written citation (Order to Comply) will be issued, citing the sections of the law, standards, rules or regulations alleged to be violated, the location of the violation, the abatement period, posting requirements and will also include the employer's and employee's right to contest any or all orders.

Although the State Plan does not provide for first instance sanctions, it does provide for monetary penalties for failures-to-abate and willful and repeated violations. The State Act (N.J.S.A., Section 34:6A–41(d)) provides that if the time for compliance with an order has elapsed, and the employer has not contested and has not made a good faith effort to comply, the Commissioner of Labor shall impose a civil administrative penalty of up to $7,000 per day for each violation. In addition, any employer who willfully or repeatedly violates the requirements of any standard, rule, order or regulation shall be assessed a civil administrative penalty of up to $70,000 for each violation. Penalties may be recovered with costs in a civil action commenced by the Commissioner by a summary proceeding under the Penalty Enforcement Law. (N.J.S.2A:58–1 *et seq.*) The State has given an assurance that it will adopt appropriate penalty procedures that will include gravity-based penalties (severity and probability) as well as penalty adjustment factors (size, history, and good faith) as a part of its developmental step commitment to adopt amendments to regulations regarding inspections, citations, and proposed penalties equivalent to 29 CFR 1903 within one year after state plan approval. Specific regulations and detailed procedures on compliance orders, abatement and sanctions will be submitted by New Jersey in accordance with its developmental schedule. (New Jersey State plan, pp. 96–96.)

(h) *Contested Cases.* A State plan must have authority and procedures for employer contest of violations alleged by the State, penalties/sanctions and abatement requirements at full administrative or judicial hearings. Employees must also have the right to contest abatement periods and the opportunity to participate as parties in all proceedings resulting from an employer's contest (29 CFR 1956.11(c)(2)(xi)).

The State Act provides that any employer, employee or employee representative affected by a determination of the Commissioner of Labor may file with the Commissioner, within fifteen working days of the issuance of an order to comply, a notice to contest any provision of the order. (N.J.S.A. Sections 34:6A–36, 41 and N.J.A.C. 12:110–4.13.) The Commissioner must immediately advise the Occupational Safety and Health Review Commission of the notification and the Commission will afford an opportunity for a hearing. The Review Commission will issue an order, based on a finding of fact, affirming, modifying, or vacating the Commissioner's order to comply or the proposed penalty, or directing other appropriate relief, and the order shall become final 45 days after its issuance. (N.J.S.A. 34:6A–42) N.J.A.C. 12:110, establishes the opportunity for the Commissioner of Labor to hold an informal conference. Such a conference would be for the purpose of discussing any issue raised by an inspection, order to comply, a notice of proposed penalty, or notice of intention to contest. No such conference or request for such conference will serve as a stay of any 15 working day period for filing a notice of intention to contest as prescribed in N.J.A.C. 12:110–4.14. Appeals from decisions of the Review Commission are to the Appellate Division of the Superior Court. (N.J.S.A. 34:6A–43)

(i) *Enforcement Conclusion.* Accordingly, OSHA finds that the enforcement provisions of the New Jersey State plan as described above meet or will meet the statutory and regulatory requirements for initial State plan approval.

6. Staffing and Resources

Section 18(c)(4) of the OSH Act requires State plans to provide the qualified personnel necessary for the enforcement of standards. In accordance with 29 CFR 1956.10(g), one factor which OSHA must consider in considering a plan for initial approval is whether the State has or will have a sufficient number of adequately trained and competent personnel to discharge its responsibilities under the plan.

The New Jersey State plan (pp. 150–154) provides assurances of a fully trained, adequate staff, including 20 safety and 7 health compliance officers for enforcement inspections, and 4 safety and 3 health consultants to perform consultation services in the public sector, and 2 safety and 3 health training and education staff. The compliance staffing requirements (or benchmarks) for State plans covering both the private and public sectors are established based on the ''fully effective'' test established in *AFL–CIO* v. *Marshall*, 570 F.2d 1030 (D.C. Cir., 1978). This staffing test, and the formula used to derive benchmarks for complete private/public sector plans, is not intended, nor is it appropriate, for application to the staffing needs of public employee only plans. However, the State has given satisfactory assurance (New Jersey State plan, p.156) that it will meet the staffing requirements of 29 CFR 1956.10.

Section 18(c)(5) of the OSH Act requires that the State plan devote adequate funds to administration and enforcement of its standards (29 CFR 1956.10(h)). New Jersey has funded its public employee occupational safety and health program since 1984 solely utilizing State funds. The State plan will be funded at $5,118,360 ($1,771,000 Federal 50% share; $1,771,000 State 50% matching share; $1,576,360 100% State funds) during federal fiscal year 2001.

Accordingly, OSHA finds that the New Jersey State plan has provided for sufficient, qualified personnel and adequate funding for the various activities to be carried out under the plan.

7. Records and Reports

State plans must assure that employers in the State submit reports to the Secretary in the same manner as if the plan were not in effect (section 18(c)(7)) of the OSH Act). Under a public employee State plan, public employers must maintain records and

make reports on occupational injuries and illnesses in a manner similar to that required of private sector employers under the OSH Act and (29 CFR 1956.10(i)). The plan must also provide assurances that the designated agency will make such reports to the Secretary in such form and containing such information as he may from time to time require (section 18(c)(8) of the OSH Act and 29 CFR 1956.10(j)).

New Jersey has provided assurance in its State plan (pp. 139–144) that all jurisdictions covered by the State plan will maintain valid records and make timely reports on occupational injuries and illnesses as required for private employers under the OSH Act. Specific regulations on this aspect of the State plan will be submitted by New Jersey in accord with its developmental schedule in which the State has agreed to adopt amendments to regulations regarding recordkeeping equivalent to 29 CFR part 1904 within two years after state plan approval. Current State recordkeeping regulations, at N.J.A.C. 12:110–5., infer that employees' names may be considered confidential. As this conflicts with the Federal requirement at 29 CFR 1904.7 which provides for full access to the OSHA Log including Column C, ''Employee's Name,'' for compliance staff, employees, former employees and employee representatives, the State has provided assurance that it will comply with § 1904.7 upon plan approval and will amend its regulation accordingly. (New Jersey State Plan, p. 140)

New Jersey has also provided assurance in its State plan (pp. 144 and 148) that it will continue its participation in the Bureau of Labor Statistics Annual Survey of Injuries and Illnesses (for the private sector) and will similarly continue its statistical survey of the public sector under its approved plan. The New Jersey State plan also contains assurances that it will provide reports to OSHA in the desired form and participate in OSHA's Integrated Management Information System. (New Jersey State plan, pp. 145–148)

OSHA finds that the New Jersey State plan has met the requirements of section 18(c)(7) and (8) of the OSH Act on employer and State reports to the Secretary.

8. Voluntary Compliance Program

A State plan must undertake programs to encourage voluntary compliance by employers by such means as conducting training and consultation with employers and employees (29 CFR 1956.11(c)(2)(xii)).

The New Jersey State plan (pp.125–130) provides that the State Labor and Health Departments will include voluntary compliance as an essential component of its program. Training will be provided to public employers and employees; seminars will be conducted to familiarize affected individuals with OSHA standards and requirements, and safe work practices; and, an on-site consultation program in the public sector parallel to New Jersey State's existing private sector on-site consultation program (under section 21(d) of the OSH Act) will be established. The public employee consultation program will have both safety and health consultants available to employers who request such service. All State agencies and political subdivisions will also be encouraged to develop and maintain self-inspection programs and to develop internal safety and health programs in accordance with the State public employee safety and health program guidelines. The State has committed under its developmental schedule to fully implement public employer/employee consultation, training and education program equivalent to 29 CFR part 1908 within three years after state plan approval.

OSHA finds that the New Jersey State plan provides for the establishment and administration of an effective voluntary compliance program.

E. Decision

OSHA, after carefully reviewing the New Jersey State plan for the development and enforcement of State standards applicable to State and local government employees and the record developed during the above described proceedings, has determined that the requirements and criteria for initial approval of a developmental plan have been met. The plan is hereby approved as a developmental plan under section 18 of the Act and 29 CFR part 1956. This decision incorporates the requirements of the Act and of regulations applicable to State plans generally.

The initial approval of a State plan for public employees in New Jersey is not a significant regulatory action as defined in Executive Order 12866.

F. Regulatory Flexibility Act

OSHA certifies pursuant to the Regulatory Flexibility Act of 1980 (5 U.S.C. 601 *et seq.*) that the proposed initial approval of the New Jersey State Plan will not have a significant economic impact on a substantial number of small entities. By its own terms, the plan will have no effect on private sector employment, but is limited to the State and its political subdivisions. Moreover, the New Jersey legislation has been in effect since 1984, when the State first established a safety and health program for State and local government employees. Since that time, the New Jersey program has been in operation with State funding and most public sector employers in the State, including small units of local government, have been subject to its terms. Compliance with State OSHA standards is required by State law; Federal approval of a State plan imposes regulatory requirements only on the agency responsible for administering the State plan. Accordingly, no new obligations would be placed on public sector employers as a result of Federal approval of the plan.

G. Federalism

Executive Order 13132, ''Federalism,'' emphasizes consultation between Federal agencies and the States and establishes specific review procedures the Federal government must follow as it carries out policies which affect state or local governments. OSHA has consulted extensively with New Jersey throughout the development, submission and consideration of its proposed State plan. Although OSHA has determined that the requirements and consultation procedures provided in Executive Order 13132 are not applicable to initial approval decisions under the Act, which have no effect outside the particular State receiving the approval, OSHA has reviewed the New Jersey initial approval decision proposed today, and believes it is consistent with the principles and criteria set forth in the Executive Order.

H. List of Subjects in 29 CFR PART 1956

Intergovernmental relations, Law enforcement, Occupational Safety and Health, Reporting and recordkeeping requirements.

I. Effective Date January 11, 2001

OSHA's decision granting initial Federal approval to the New Jersey State plan for public employees only is effective January 11, 2001. The program described in the plan has been in effect for many years and no immediate modifications of the program are required by today's decision. Federal 50% matching funds have been explicitly provided in the Department of Labor's FY 2001 appropriation. Notice of proposed initial approval of the plan was published both in the **Federal Register** and in several newspapers throughout the State with requests for comment. No comments opposing initial approval of the plan were received, and OSHA believes that no

party is adversely affected by initial approval of the plan. OSHA therefore finds, pursuant to section 553(d) of the Administrative Procedures Act, that good cause exists for making Federal approval of the New Jersey Public Employee Only State plan effective upon publication in the **Federal Register**.

J. Authority

This document was prepared under the direction of Charles N. Jeffress, Assistant Secretary of Labor for Occupational Safety and Health. It is issued under Section 18 of the OSH Act, (29 U. S. C. 667), 29 CFR parts 1902 and 1956, and Secretary of Labor's Order No. 3–2000 (65 FR 50017).

Signed at Washington, D.C. this 4th of January, 2000.

Charles N. Jeffress,

Assistant Secretary of Labor.

For the reasons set out in the preamble, 29 CFR Part 1956 is hereby amended by adding a new Subpart G as follows:

Subpart G—New Jersey

Sec.

1956.60 Description of the plan as initially approved.
1956.61 Developmental schedule.
1956.62 Completion of developmental steps and certification. [Reserved]
1956.63 Determination of operational effectiveness. [Reserved]
1956.64 Location of plan for inspection and copying.

Subpart G—New Jersey

Authority: Section 18 of the OSH Act, (29 U.S.C. 667), 29 CFR Part 1902, 29 CFR 1956, and Secretary of Labor's Order No. 3–2000 (65 FR 50017).

§ 1956.60 Description of the plan as initially approved.

(a) *Authority and scope.* The New Jersey State Plan for Public Employee Occupational Safety and Health received initial OSHA approval on January 11, 2001. The plan designates the New Jersey Department of Labor as the State agency responsible for administering the plan throughout the State. The plan includes enabling legislation, Public Employees Occupational Safety and Health Act of 1995 (N.J.S.A. 34:6A–25 *et seq.*), enacted in 1984, and amended on July 25, 1995. Under this legislation, the State Commissioner of Labor has full authority to enforce and administer all laws and rules protecting the safety and health of all employees of the State and its political subdivisions under the Public Employee Occupational Safety and Health program (PEOSH). The Commissioner of Health and Senior Services has authority for occupational health matters including the authority to conduct health inspections, investigations and related activities. However, all standards adoption and enforcement authority for both occupational safety and health remain the responsibility of the New Jersey Department of Labor.

(b) *Standards.* New Jersey has adopted State standards identical to OSHA occupational safety and health standards promulgated as of December 7, 1998, with differences only in its hazard communication and fire protection standards. The State plan includes a commitment to bring those two (2) standards into conformance with OSHA requirements and to update all standards within one year after plan approval. The State plan also provides that future OSHA standards and revisions will be adopted by the State within six (6) months of Federal promulgation, in accordance with 29 CFR 1953.21. Any emergency temporary standards will be adopted within 30 days of Federal adoption. The State will adopt Federal OSHA standards in accordance with the provisions of New Jersey statute, N.J.S.A. 52:14B–5; Federal standards shall be deemed to be duly adopted as State regulations upon publication by the Commissioner of Labor. The plan also provides for the adoption of alternative or different occupational safety and health standards by the Commissioner of Labor in consultation with the Commissioner of Health and Senior Services, the Commissioner of Community Affairs, and the Public Employee Occupational Safety and Health Advisory Board, where no Federal standards are applicable to the conditions or circumstances or where standards more stringent than the Federal are deemed advisable.

(c) *Variances.* The plan includes provisions for the granting of permanent and temporary variances from State standards in terms substantially similar to the variance provisions contained in the OSH Act. The State provisions require employee notification of variance applications as well as employee rights to participate in hearings held on variance applications. Variances may not be granted unless it is established that adequate protection is afforded employees under the terms of the variance. The State has committed to amend its current variance procedures at N.J.A.C. 12:110–6 to bring them into conformance with Federal procedures at 29 CFR Part 1905 within two years after state plan approval.

(d) *Employee notice and discrimination protection.* The plan provides for notification to employees of their protections and obligations under the plan by such means as a State poster, and required posting of notices of violations. The plan also provides for protection of employees against discharge or discrimination resulting from exercise of their rights under the State's Act in terms similar to section ll(c) of the OSH Act. However, employees have 180 days to file complaints of discrimination with the Commissioner of Labor; and the Commissioner is authorized to both investigate and order all appropriate relief. The monetary penalty for repeated violations (up to $70,000 per violation) may also be applicable to repeated employer acts of discrimination.

(e) *Inspections and enforcement.* The plan provides for inspection of covered workplaces including inspections in response to employee complaints, by both the Department of Labor, and by the Department of Health and Senior Services with regard to health issues. If a determination is made that an employee complaint does not warrant an inspection, the complainant shall be notified, in writing, of such determination and afforded an opportunity to seek informal review of the determination. The plan also provides the opportunity for employer and employee representatives to accompany the inspector during an inspection for the purpose of aiding in the inspection. Employee(s) accompanying an inspector are entitled to normal wages for the time spent during the inspection. The plan also provides for right of entry for inspection and prohibition of advance notice of inspection. The Commissioner of Labor is responsible for all enforcement actions including the issuance of citations/Orders to Comply which must also specify the abatement period, posting requirements and the employer's and employee's right to contest any or all orders. Although the plan does not provide for initial (first instance) monetary sanctions, the Commissioner of Labor has the authority to impose civil administrative penalties of up to $7,000 per day for each violation, for failure to abate, if the time for compliance with an order has elapsed, and the employer has not contested and has not made a good faith effort to comply. Willful or repeated violations also are subject to civil administrative penalties of up to $70,000 for each violation. Penalties may be recovered with costs in a civil

action brought under the New Jersey Penalty Enforcement Act (N.J.S.2A.:58–1 *et seq.*)

(f) *Review procedures.* Under the plan, employers, employees and other affected parties may seek informal review with the Department of Labor relative to a notice of violation/Order to Comply, the reasonableness of the abatement period, any penalty and/or may seek formal administrative review with the Occupational Safety and Health Review Commission, a board appointed by the Governor and authorized under section 34:6A.42 of the New Jersey Act to hear and rule on appeals of orders to comply and any penalties proposed. Any employer, employee or employee representative affected by a determination of the Commissioner may file a contest within fifteen (15) working days of the issuance of an order to comply. The Review Commission will issue an order, based on a finding of fact, affirming, modifying, or vacating the commissioner's order to comply or the proposed penalty, or directing other appropriate relief, and the order shall become final 45 days after its issuance. Judicial review of the decision of the Review Commission may be sought at the Appellate Division of the Superior Court.

(g) *Staffing and Resources.* The plan further provides assurances of a fully trained, adequate staff, including 20 safety and 7 health compliance officers for enforcement inspections, and 4 safety and 3 health consultants to perform consultation services in the public sector, and 2 safety and 3 health training and education staff. The State has assured that it will continue to provide a sufficient number of adequately trained and qualified personnel necessary for the enforcement of standards as required by 29 CFR 1956.10. The State has also given satisfactory assurance of adequate funding to support the plan.

(h) *Records and reports.* The plan provides that public employers in New Jersey will maintain appropriate records and make timely reports on occupational injuries and illnesses in a manner substantially identical to that required for private sector employers under Federal OSHA. New Jersey has assured that it will continue its participation in the Bureau of Labor Statistics Annual Survey of Injuries and Illnesses with regard to both private and public sector employers. The State will comply with the provisions of 29 CFR 1904.7 which allows full employee and employee representative access, including employee's names, to the log of workplace injuries and illnesses; and will amend its regulations accordingly. The plan also contains assurances that the Commissioner of Labor will provide reports to OSHA in such form as the Assistant Secretary may require, and that New Jersey will participate in OSHA's Integrated Management Information System.

(i) *Voluntary compliance programs.* The plan provides that training will be provided to public employers and employees; seminars will be conducted to familiarize affected individuals with OSHA standards, requirements and safe work practices; an on-site consultation program in the public sector will be established to provide services to public employers who so desire; and, all State agencies and political subdivisions will be encouraged to develop and maintain self inspection programs as well as internal safety and health programs as an adjunct to but not a substitute for the Commissioner of Labor's enforcement.

§ 1956.61 Developmental Schedule.

The New Jersey State plan is developmental. The following is a schedule of major developmental steps as provided in the plan:

(a) Adopt standards identical to or at least as effective as all existing OSHA standards within one year after plan approval.

(b) Adopt amendments to regulations regarding inspections, citations, and proposed penalties equivalent to 29 CFR part 1903 within one year after plan approval.

(c) Develop a five year strategic plan within two years after plan approval.

(d) Develop field inspection reference manual and/or field operations manual within two years after plan approval.

(e) Fully implement public employer/employee consultation, training and education program equivalent to 29 CFR part 1908 within three years after plan approval.

(f) Adopt amendments to regulations regarding discrimination against employees equivalent to 29 CFR part 1977 within two years after plan approval.

(g) Adopt amendments to regulations regarding variances equivalent to 29 CFR part 1905 within two years after plan approval.

(h) Adopt amendments to regulations regarding record keeping equivalent to 29 CFR part 1904 within two years after plan approval.

§ 1956.62 Completion of developmental steps and certification. (Reserved).

§ 1956.63 Determination of operational effectiveness. (Reserved).

§ 1956.64 Location of plan for inspection and copying.

A copy of the plan may be inspected and copied during normal business hours at the following locations: Office of State Programs, U.S. Department of Labor, Occupational Safety and Health Administration, 200 Constitution Avenue, N.W., Room N–3700, Washington, D.C. 20210; Office of the Regional Administrator, U.S. Department of Labor, Occupational Safety and Health Administration, 1201 Varick Street, Room 670, New York, New York 10014; and New Jersey Department of Labor, Division of Public Safety and Occupational Safety and Health, Office of Public Employees' Safety, P.O. Box 386, 225 East State Street, 8th Floor West, Trenton, New Jersey 08625–0386.

[FR Doc. 01–684 Filed 1–10–01; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 141

[FRL–6920–6]

RIN 2040–AD58

Unregulated Contaminant Monitoring Regulation for Public Water Systems; Analytical Methods for List 2 Contaminants; Clarifications to the Unregulated Contaminant Monitoring Regulation

AGENCY: Environmental Protection Agency.

ACTION: Final rule.

SUMMARY: The Safe Drinking Water Act (SDWA), as amended in 1996, requires the U.S. Environmental Protection Agency to establish criteria for a program to monitor unregulated contaminants and to publish a list of contaminants to be monitored. In fulfillment of this requirement, EPA published the Revisions to the Unregulated Contaminant Monitoring Regulation (UCMR) for public water systems on September 17, 1999, which included lists of contaminants for which monitoring was required or would be required in the future. These lists included: List 1 for contaminants with approved analytical methods; List 2 for contaminants with methods that were being refined; and List 3 for

contaminants with methods that were still being developed.

Today's rule approves the analytical methods for thirteen chemical contaminants on List 2, and requires monitoring for those contaminants in drinking water. This rule also sets the schedule for monitoring one microbiological contaminant, *Aeromonas,* contingent on promulgation of its analytical method. These methods and associated monitoring will be used to support EPA decisions concerning whether or not to regulate and establish standards for these contaminants in drinking water. The intent of regulating and setting standards for any of these contaminants that may be found to occur at levels of health concern is to protect public health. Additionally, in today's rule, EPA includes modifications to the UCMR (published September 17, 1999) that affect the implementation of monitoring for both List 1 and List 2 contaminants.

DATES: *Effective Date:* The final rule is effective January 11, 2001.

The incorporation by reference of the publications listed in today's rule is approved by the Director of the Federal Register as of January 11, 2001.

For purposes of judicial review, this final rule is promulgated as of 1 p.m. Eastern time on January 11, 2001, as provided in 40 CFR 23.7.

ADDRESSES: Documents relevant to this action are available for inspection from 9 a.m. to 4 p.m., Eastern Time, Monday through Friday, excluding legal holidays, at the Water Docket, East Tower Basement, Room 57, U.S. EPA, 401 M Street, SW., Washington DC. For access to docket (Docket No. W–00–01) materials, please call (202) 260–3027 between 9 a.m. and 3:30 p.m, Eastern Time, Monday through Friday, to schedule an appointment. A reasonable fee may be charged for copying.

FOR FURTHER INFORMATION CONTACT: Charles Job, Drinking Water Protection Division, Office of Ground Water and Drinking Water (MC–4607), U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue, NW., Washington D.C. 20460, (202) 260–7084. General information may also be obtained from the EPA Safe Drinking Water Hotline. Callers within the United States may reach the Hotline at (800) 426–4791. The Hotline is open Monday through Friday, excluding federal holidays, from 9 a.m. to 5:30 p.m. Eastern Time.

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Abbreviations and Acronyms Used in the Preamble and Final Rule

2,4-DNT—2,4-dinitrotoluene
2,6-DNT—2,6-dinitrotoluene
4,4′-DDE—4,4′-dichloro dichlorophenyl ethylene, a degradation product of DDT
Alachlor ESA—alachlor ethanesulfonic acid, a degradation product of alachlor
AOAC—Association of Official Analytical Chemists
APHA—American Public Health Association
ASDWA—Association of State Drinking Water Administrators
ASTM—American Society for Testing and Materials
CAS—Chemical Abstract Service
CASRN—Chemical Abstract Service Registry Number
CCL—Contaminant Candidate List
CCR—Consumer Confidence Reports
CERCLA—Comprehensive Environmental Response, Compensation & Liability Act
CFR—Code of Federal Regulations
CFU/mL—colony forming units per milliliter
CWS—community water system
DCPA—dimethyl tetrachloroterephthalate, chemical name of the herbicide dacthal
DCPA mono- and di-acid degradates—degradation products of DCPA
DDE—dichloro dichlorophenyl ethylene, a degradation product of DDT
DDT—dichloro diphenyl trichloroethane, a general insecticide
DNA—deoxyribonucleic acid
EDL—estimated detection limit
EPA—Environmental Protection Agency
EPTC—s-ethyl-dipropylthiocarbamate, an herbicide
EPTDS—Entry Point to the Distribution System
ESA—ethanesulfonic acid, a degradation product of alachlor and other acetanilide pesticides
FACA—Federal Advisory Committee Act
FSIS—federalism summary impact statement
FTE—full-time equivalent
GC—gas chromatography, a laboratory method
GLI method—Great Lakes Instruments method
GW—ground water
GUDI—ground water under the direct influence (of surface water)
HPLC—high performance liquid chromatography, a laboratory method
IC—ion chromatography
ICR—Information Collection Rule
IRFA—initial regulatory flexibility analysis
IMS—immunomagnetic separation
IRIS—Integrated Risk Information System
IS—internal standard
LLE—liquid/liquid extraction, a laboratory method
MAC—*Mycobacterium avium* complex
MCL—maximum contaminant level
MCT—matrix conductivity threshold
MDL—method detection limit
MOA—Memorandum of agreements
MRL—minimum reporting level
MS—mass spectrometry, a laboratory method
MS—sample matrix spike
MSD—sample matrix spike duplicate
MTBE—methyl tertiary-butyl ether, a gasoline additive
NAICS—North American Industry Classification System
NAWQA—National Water Quality Assessment Program
NCOD—National Drinking Water Contaminant Occurrence Database
NDWAC—National Drinking Water Advisory Council
NERL—National Environmental Research Laboratory
NPS—National Pesticide Survey
NTIS—National Technical Information Service
NTNCWS—non-transient non-community water system
NTTAA—National Technology Transfer and Advancement Act
OGWDW—Office of Ground Water and Drinking Water
OMB—Office of Management and Budget
PAH—Polycyclic aromatic hydrocarbon
PB—particle beam
PBMS—Performance-Based Measurement System
pCi/L—picocuries per liter
PCR—polymerase chain reaction
^{210}Pb—Lead-210 (also Pb-210), a lead isotope and radionuclide; part of the uranium decay series
^{210}Po—Polonium-210 (also Po-210), a polonium isotope and radionuclide; part of the uranium decay series
PWS—Public Water System
PWSF—Public Water System Facility
QA—quality assurance
QC—quality control
RDX—royal demolition explosive, hexahydro-1,3,5-trinitro-1,3,5-triazine
RFA—Regulatory Flexibility Act
RPD—relative percent difference
RSD—relative standard deviation
SBREFA—Small Business Regulatory Enforcement Fairness Act
SD—standard deviation
SDWA—Safe Drinking Water Act
SDWIS—Safe Drinking Water Information System
SDWIS/FED—the Federal Safe Drinking Water Information System
SM—Standard Methods for the Examination of Water and Wastewater
SMF—Standard Compliance Monitoring Framework

SOC—synthetic organic compound
SOP—standard operating procedure
SPE—solid phase extraction, a laboratory method
spp.—multiple species
SRF—State Revolving Fund
STORET—Storage and Retrieval System
SW—surface water
TBD—to be determined
TDS—total dissolved solid
TNCWS—transient non-community water system
TTHM—total trihalomethane
UCMR—Unregulated Contaminant Monitoring Regulation/Rule
UCM—Unregulated Contaminant Monitoring
UMRA—Unfunded Mandates Reform Act of 1995
USEPA—United States Environmental Protection Agency
UV—ultraviolet
VOC—volatile organic compound
µg/L—micrograms per liter
µS/cm—microsiemens per centimeter

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Potentially Regulated Entities

The regulated entities are public water systems. All large community and non-transient non-community water systems serving more than 10,000 persons are required to monitor. A community water system (CWS) means a public water system which serves at least 15 service connections used by year-round residents or regularly serves at least 25 year-round residents. Non-transient non-community water system (NTNCWS) means a public water system that is not a community water system and that regularly serves at least 25 of the same persons over 6 months per year. Only a national representative sample of community and non-transient non-community systems serving 10,000 or fewer persons will be required to monitor. Transient non-community systems (i.e., systems that do not regularly serve at least 25 of the same persons over six months per year) will not be required to monitor. States, Territories, and Tribes, with primacy to administer the regulatory program for public water systems under the Safe Drinking Water Act, sometimes conduct analyses to measure for contaminants in water samples and are regulated by this action. Categories and entities potentially regulated by this action include the following:

Category	Examples of potentially regulated entities	NAICS
State, Territorial and Tribal Governments ...	States, Territories, and Tribes that analyze water samples on behalf of public water systems required to conduct such analysis; States, Territories, and Tribes that themselves operate community and non-transient non-community water systems required to monitor.	924110
Industry	Private operators of community and non-transient non-community water systems required to monitor.	221310
Municipalities	Municipal operators of community and non-transient non-community water systems required to monitor.	924110

This table is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be regulated by this action. This table lists the types of entities that EPA is now aware of that could potentially be regulated by this action. Other types of entities not listed in the table could also be regulated. If you have questions regarding the applicability of this action to a particular entity, consult the person listed in the preceding **FOR FURTHER INFORMATION CONTACT** section.

I. Statutory Authority

SDWA section 1445 (a)(2), as amended in 1996, requires EPA to establish criteria for a program to monitor unregulated contaminants and to issue, by August 6, 1999, a list of contaminants to be monitored. In fulfillment of this requirement, EPA published the Revisions to the Unregulated Contaminant Monitoring Regulation (UCMR) for public water systems on September 17, 1999 (64 FR 50556), which included lists of contaminants for which monitoring was required or would be required in the future. These lists included: List 1 for contaminants with approved analytical methods; List 2 for contaminants with methods that were being refined; and List 3 for contaminants with methods that were still being developed. The rule covered: (1) The frequency and schedule for monitoring, based on PWS size, water source, and likelihood of finding contaminants; (2) a new, shorter list of contaminants for which systems will monitor; (3) procedures for selecting and monitoring a nationally representative sample of small PWSs (those serving 10,000 or fewer persons); and (4) procedures for entering the monitoring data in the National Drinking Water Contaminant Occurrence Data Base (NCOD), as required under section 1445.

II. Major Program Revisions

Today's action establishes analytical methods for measurement of 13 chemical contaminants, which were included on the UCMR (1999) List 2, and requirements for monitoring of those contaminants by public water systems. The 1999 List 2 contaminants and their sources, including amendments to List 2 established today, are presented in Table 1, Uses and Environmental Sources of UCMR (1999) List 2 Contaminants. This action also establishes modifications affecting the sample collection, analysis and reporting of both List 1 and List 2 contaminants. Such modifications include clarifying source water monitoring, resampling conditions, additional methods, and clarification of definitions of some data elements for reporting. None of these changes result in a major burden or impact and some changes may reduce burden, but they should improve data quality.

TABLE 1.—USES AND ENVIRONMENTAL SOURCES OF UCMR (1999) LIST 2 CONTAMINANTS

Contaminant Name	CASRN	Use or Environmental Source
Final Chemical Contaminants		
1,2-diphenylhydrazine	122–66–7	Used in the production of benzidine and anti-inflammatory drugs.
2-methylphenol	95–48–7	Released in automobile and diesel exhaust, coal tar and petroleum refining, and wood pulping.
2,4-dichlorophenol	120–83–2	Chemical intermediate in herbicide production.
2,4-dinitrophenol	51–28–5	Released from mines, metal, petroleum, and dye plants.
2,4,6-trichlorophenol	88–06–2	By-product of fossil fuel burning, used as bactericide and wood/glue preservative.
Alachlor ESA and other acetanilide pesticides.	N/A	Degradation product of alachlor and other acetanilide pesticides, herbicides generally used with corn, bean, peanut, and soybean crops to control grasses and weeds.
Diazinon	333–41–5	Insecticide used with rice, fruit, vineyards, and corn crops.
Disulfoton	298–04–4	Insecticide used with cereal, cotton, tobacco, and potato crops.
Diuron	330–54–1	Herbicide used on grasses in orchards and wheat crops.
Fonofos	944–22–9	Soil insecticide used on worms and centipedes.
Linuron	330–55–2	Herbicide used with corn, soybean, cotton, and wheat crops.
Nitrobenzene	98–95–3	Used in the production of aniline, which is used to make dyes, herbicides, and drugs.
Prometon	1610–18–0	Herbicide used on annual and perennial weeds and grasses.
RDX (royal demolition explosive, hexahydro-1,3,5-trinitro-1,3,5-triazine).	121–82–4	Used in explosives; ammunition plants.
Terbufos	13071–79–9	Insecticide used with corn, sugar beet, and grain sorghum crops.
Microbiological Contaminant		
Aeromonas	N/A	Present in all freshwater and brackish water.

III. Summary of Today's Rule

The September 1999 rule included a list of contaminants to be monitored which was further subdivided into three lists: List 1 for contaminants with current approved analytical methods, List 2 for contaminants with methods being refined, and List 3 for contaminants with methods being developed in research. In a supplemental rule, published March 2, 2000, (65 FR 11371), the methods for two List 1 contaminants were established as were some technical corrections to the UCMR rule.

Sixteen contaminants were included on the UCMR (1999) List 2, with their analytical methods listed as ''reserved,'' pending the conclusion of EPA refinement and review of the analytical methods. EPA proposed analytical methods for 13 chemical contaminants and nitrobenzene, as well as *Aeromonas,* a microbiological contaminant, on List 2 on September 13, 2000. Today's final rule amends the 1999 UCMR to specify analytical methods for monitoring for 13 organic chemical contaminants, and it establishes the monitoring schedule for 13 contaminants (13 organic chemicals) on List 2. Today's rule adds one contaminant to List 2, nitrobenzene, (**Note**: Nitrobenzene is also on List 1 using a method with a higher minimum reporting level) and moves one other

contaminant, polonium-210, from List 2 to List 3. In addition, today's final rule activates Screening Survey monitoring for these 13 contaminants, as described in § 141.40(a)(3), Table 1, List 2. This final rule also contains several minor wording and technical changes to the September 1999 rule in response to comments received on the September 2000 proposal. Additionally, the preamble to today's rule includes discussion of EPA's responses to the comments received on the proposed rule.

IV. Process of Preparing the Final Rule

EPA has been developing the final revisions to the Unregulated Contaminant Monitoring Regulation (UCMR) for public water systems since 1997. In December 1997, EPA's UCMR development workgroup held a stakeholders meeting to obtain input from the public on major issues and options affecting the program and emanating from the Safe Drinking Water Act, as amended in 1996. EPA held a second stakeholders meeting in May 1998, on options under serious consideration for the UCMR. EPA engaged eleven external expert reviewers from March 1 through April 22, 1999, to examine and comment on the technical aspects of the UCMR. These technical reviewers evaluated and commented on the chemical and microbiological contaminant analytical methods and reporting requirements, the statistical approach for the representative sample of small systems, and the sampling and monitoring approach. The comments of the technical reviewers were available to the public through the official docket and on the Internet through EPA's Office of Ground Water and Drinking Water electronic homepage.

The comment period on the original UCMR revision (published in the **Federal Register** on April 30, 1999) closed on June 14, 1999, with submissions from 155 commenters meeting the deadline and addressing all major aspects of the proposed rule.

The final rule on the original UCMR revisions was published on September 17, 1999 (64 FR 50556). EPA conducted five national workshops on implementation of the final regulation. At these workshops, EPA received many comments from State, Tribal and Regional participants concerning various aspects of implementing the rule. As a result of this additional input, EPA subsequently modified the original UCMR on March 2, 2000 (65 FR 11371) through a direct final rule and proposed additional changes to the original rule on September 13, 2000. Today's final rule promulgates the modifications proposed on September 13, 2000 (in addition to establishing List 2 monitoring requirements).

The comment period for the September 13, 2000, List 2 proposal (65 FR 55362) closed on October 13, 2000. EPA received 15 comments which were submitted within the specified comment period. These comments addressed all major aspects of the proposal and EPA considered and addressed all comments in the process of developing this final regulation.

V. Explanation of Today's Action

A. Relation to the UCMR Published in September 1999

The final UCMR, published on September 17, 1999, and subsequently revised on March 2, 2000, consisted of many program elements designed to enhance and improve the unregulated contaminant monitoring program in several important ways. The rule specifies (1) which systems must monitor, including a statistical approach to select a representative sample of small public water systems; (2) a list of contaminants for which systems must monitor; (3) the monitoring time, frequency, and location of sampling; (4) which methods are to be used for analyzing the contaminants; (5) quality control elements that must be followed in addition to those specified in each analytical method; (6) reporting requirements; and (7) State and Tribal participation concerning the implementation of the monitoring program.

EPA divided the list of contaminants for which systems must monitor into three separate lists based on the availability of analytical methods and the scope of monitoring to be required. List 1, Assessment Monitoring, consisted of 12 contaminants for which analytical methods were available. List 2, Screening Survey, consisted of 16 contaminants for which EPA expected analytical methods would be developed by the time of initial monitoring in 2001. Pre-Screen Testing, List 3, consisted of eight contaminants for which analytical methods research was being conducted. Only the contaminants on List 1 must be monitored at all 2,774 large community and non-transient non-community public water systems serving more than 10,000 persons, and at a representative sample of approximately 800 systems serving 10,000 or fewer persons. From this set of approximately 3,600 large and small public water systems, EPA has randomly selected approximately 300 large and small systems to monitor for List 2 contaminants in Screening Surveys. Today's rule specifies the analytical methods for 13 List 2 contaminants. The method for the microbiological contaminant, *Aeromonas,* is reserved in today's notice, but EPA expects to promulgate EPA Method 1605 in 2001. Methods for the other two List 2 contaminants, RDX and Alachlor ESA, need to be refined for analysis in treated drinking water.

The placement of 16 contaminants on List 2 meant that their analytical methods were being further refined and were not ready for the extensive monitoring that would occur for the List 1 contaminants. The evaluation of the 13 new methods during monitoring for List 2 contaminants will include developing the data necessary to support the determination of practical quantitation levels, which are needed to support possible future regulations, as well as determining the occurrence of the analytes measured. Today's final rule provides for monitoring 13 List 2 chemical contaminants at the 180 small systems randomly selected from the 800 small systems in the State Monitoring Plans beginning in January 2001 (with the small systems (or State) doing the sampling and EPA conducting the testing and reporting). State Monitoring Plans (SMPs) collectively specify the 800 randomly selected small water systems serving 10,000 or fewer persons and constitute the national representative sample of small systems. The SMPs also collectively specify 120 randomly selected large systems that must monitor for List 2 contaminants, beginning in January 2002. A second Screening Survey for one List 2 microbiological contaminant *(Aeromonas)* will be performed in 2003 by 180 other small systems and 120 other large systems once the final method is promulgated. The delay of the Screening Survey for the microbiological contaminant will allow EPA to publish the new method and will allow time for laboratories to gain experience with the new method and have capacity available for large system testing.

The rule establishes timing that will allow monitoring of these List 2 contaminants at small systems concurrently with the List 1, Assessment Monitoring, contaminants. Small systems will monitor in 2001 for List 2 contaminants ahead of large systems in 2002 because EPA is paying for the small system monitoring, and also plans to review the performance of the methods prior to large system monitoring, which must be paid for by the large systems.

Methods are still being refined for the remaining two List 2 chemical contaminants. If methods for these contaminants are developed in a timely fashion, they may be added for monitoring in a separate rule, probably during the next UCMR 5-year regulatory cycle.

As provided in the September 1999 rule (64 FR 50556), surface water systems will monitor quarterly for one year, and ground water systems will monitor twice in one year for List 2 chemical contaminants. Today's final rule specifies quarterly monitoring for microbiological contaminants with monthly monitoring during the vulnerable (warm) quarter. List 1 Assessment Monitoring must be done within the three years of 2001 through 2003, which is intended to allow coordination with the three-year compliance monitoring cycle for regulated contaminants. The exceptions that would involve Assessment Monitoring beyond 2003 include: loss of samples for any reason, necessitating another sampling event, or initiating sampling at entry points to the distribution system if contaminants are found in systems that conduct their other compliance monitoring at source (raw) water sampling points. One of these quarterly or semiannual sampling events must occur in the most vulnerable period of May through July, or an alternate vulnerable period designated by the State, to ensure monitoring of seasonally elevated contaminant concentrations.

B. Systems Affected by This Rule

The focus of UCMR List 2 is on the occurrence or likely occurrence of contaminants in drinking water of community and non-transient, non-community water systems. For regulatory purposes, public water systems are categorized as ''community water systems,'' or ''non-community water systems.'' Community water systems are specifically defined as ''public water systems which serve at least 15 service connections used by year-round residents or regularly serve at least 25 year round residents'' (40 CFR 141.2). A ''non-community water system'' means any other public water system. Non-community water systems include non-transient non-community water systems and transient non-community water systems. Non-transient non-community systems are those that regularly serve at least 25 of the same persons over six months per year (e.g., schools, industrial buildings). Transient systems are all other non-community systems, which typically serve a transient population such as restaurants or hotels. As explained in the September 1999 UCMR, EPA is excluding transient water systems from monitoring for unregulated contaminants, including those on List 2. The results from the small community and non-transient non-community systems can be extrapolated to the transient non-community systems, if needed.

With respect to size, about 2,800 large systems (defined here as those serving more than 10,000 persons) provide drinking water to about 80 percent of the U.S. population that is served by public water systems. The SDWA does not provide for EPA funding of this monitoring. Under the UCMR program, all large systems are required to monitor for List 1 unregulated contaminants. Only a representative sample of systems serving 10,000 persons or fewer can be required to monitor for unregulated contaminants. SDWA authorizes EPA to pay for the reasonable testing costs for the national representative sample of small systems.

As described in the September 17, 1999, **Federal Register** (64 FR 50556), EPA has selected 300 large and small systems from the systems required to conduct Assessment Monitoring for List 1 to participate in the monitoring for List 2 contaminants. The 300 systems were divided as follows: 120 large systems serving more than 10,000 persons and 180 small systems serving 10,000 or fewer persons. These allocations were approximately subdivided as follows: For the large systems, 60 systems were selected from systems serving more than 50,000 persons and 60 were from systems serving from 10,001 to 50,000 persons. For the small systems, 60 systems were selected from each of the following service size categories: 25 to 500 persons, 501 to 3,300 persons, and 3,301 to 10,000 persons. These systems were further allocated by water source type and were randomly selected from the systems required to conduct Assessment Monitoring for List 1 contaminants. The final systems selected are identified in the final State Monitoring Plans that EPA is sending to the States. The final allocations may vary from these numbers based on the State Monitoring Plan review and final system selection.

TABLE 2.—STATUS OF ANALYTICAL METHODS FOR CHEMICAL CONTAMINANTS ON THE UCMR (1999) LIST

	CAS#	Availability of analytical methods	Status of availability
UCMR (1999) List 1—Chemical Contaminant:			
2,4-dinitrotoluene	121–14–2	EPA Method 525.2	Methods is adequate for List 1 monitoring.
2,6-dinitrotoluene	606–20–2	EPA Method 525.2	Method is adequate for List 1 monitoring.
4,4'–DDE	72–55–9	EPA Method 508, EPA Method 508.1, EPA Method 525.2, D5812–96, AOAC 990.06.	Methods are adequate for List 1 monitoring.
Acetochlor	34256–82–1	EPA Method 525.2	Method is adequate for List 1 monitoring.
DCPA di acid degradate	2136–79–0	EPA Method 515.1, EPA Method 515.2, EPA Method 515.3, EPA Method 515.4, D5317–93, AOAC 992.32.	Methods are adequate for List 1 monitoring.
DCPA mono acid degradate	887–54–7	EPA Method 515.1, EPA Method 515.2, EPA Method 515.3, EPA Method 515.4, D5317–93, AOAC 992.32.	Methods are adequate for List 1 monitoring.
EPTC	759–94–4	EPA Method 507, EPA Method 525.2, D5475–93, AOAC 991.07.	Methods are adequate for List 1 monitoring.
Molinate	2212–67–1	EPA Method 507, EPA Method 525.2, D5475-93, AOAC 991.07.	Methods are adequate for List 1 monitoring.
MTBE	1634–04–4	EPA Method 502.2, EPA Method 524.2, D5790–95, SM6210D, SM6200B, SM6200C.	

TABLE 2.—STATUS OF ANALYTICAL METHODS FOR CHEMICAL CONTAMINANTS ON THE UCMR (1999) LIST—Continued

	CAS#	Availability of analytical methods	Status of availability
Nitrobenzene	98–95–3	EPA Method 524.2, D5790–95, SM6210D, SM6200B.	Methods are adequate for List 1 monitoring.
Perchlorate	14797–73–0	EPA Method 314.0	Method is adequate for List 1 monitoring.
Terbacil	5902–51–2	EPA Method 507, EPA Method 525.2, D5475–93, AOAC 991.07.	Methods are adequate for List 1 monitoring.
UCMR (1999) List 2—Chemical Contaminant			
1,2-diphenylhydrazine	122–66–7	EPA Method 526	Methods is adequate for List 2 Monitoring in 2001–2002 [a]
2,4,6-trichlorophenol	88–06–2	EPA Method 528	Method is adequate for List 2 Monitoring in 2001–2002 [a]
2,4-dichlorophenol	120–83–2	EPA Method 528	Method is adequate for List 2 Monitoring in 2001–2002 [a]
2,4-dinitrophenol	51–28–5	EPA Method 528	Methods is adequate for List 2 Monitoring in 2001–2002 [a]
2-methyl-phenol	95–48–7	EPA Method 528	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Alachlor ESA and degradation by-products of acetanilide pesticides.		Being refined	Candidate for a 3rd Screening Survey, if conducted
Diazinon	333–41–5	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Disulfoton	298–04–4	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Diuron	330–54–1	EPA Method 532	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Fonofos	944–22–9	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Linuron	330–55–2	EPA Method 532	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Nitrobenzene	98–95–3	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
Prometon	1610–18–0	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
RDX	121–82–4	Being refined	Candidate for a 3rd Screening Survey, if conducted
Terbufos	13071–79–9	EPA Method 526	Method is adequate for List 2 Monitoring in 2001–2002 [a]
UCMR (1999) List 3—Chemical Contaminant:			
Polonium-210 (^{210}Po)	13981–52–7	In development	Radichemistry laboratory capacity is limited.
Lead-210 (^{210}Pb)	14255–04–0	In development	Method is time-consuming and expensive. Radiochemistry laboratory capacity is limited.

[a] Small systems selected for the Screening Survey One will monitor for these contaminants in 2001, and large systems selected for the Screening Survey One will monitor in 2002.

TABLE 3.—STATUS OF ANALYTICAL METHODS FOR MICROBIOLOGICAL CONTAMINANTS ON THE UCMR (1999) LIST

	Availability of Analytical Methods	Status of Availability
UCMR (1999) List 2—Microbiological Contaminants:		
Aeromonas	Reserved	Method has been proposed. EPA expects to promulgate the method in 2001.
UCMR (1999) List 3—Microbiological Contaminants:		
Cyanobacteria (blue-green algae, other freshwater algae and their toxins).	Methods available but not standardized.	Methods are avialable for counting cyanobacteria but new, standardized methods are needed for direct counts of targeted species with filtration methods or a counting chamber. Standardized analytical methods are also needed to detect the more important cyanobacterial toxins.
Echoviruses	Methods available but not standardized.	Echoviruses can be cultured on BGM cells available and detected by the ICR method but require supplemental methods such as serological typing to distinguish echoviruses from other viruses. Cost of cell culture assays plus serotyping can be high. RT/PCR methods are subject to interferences and do not demonstrate infectivity. Combined cell culture and PCR, which demonstrates infectivity, may be considered.

TABLE 3.—STATUS OF ANALYTICAL METHODS FOR MICROBIOLOGICAL CONTAMINANTS ON THE UCMR (1999) LIST—Continued

	Availability of Analytical Methods	Status of Availability
Coxsackieviruses	Methods available but not standardized.	Group B coxsackieviruses are easy to grow in tissue culture but group A coxsackievirus detection in cell culture is variable. Culturable coxsackieviruses can be detected with the ICR method but serological typing is needed to distinguish coxsackieviruses from other viruses. RT/PCR methods are subject to interferences and do not demonstrate infectivity. New, standardized methods are needed. Combined cell culture and PCR methods may be considered.
Helicobacter pylori	No suitable method currently available.	*Helicobacter pylori* is difficult to cultivate because of its slow growth rate and the need for a low oxygen environment. No selective medium exists that will discriminate *H. pylori* from background bacteria. A culture-based method that demonstrates viability is preferred. Methods are needed for selective growth and identification. IMS has been used to concentrate *Helicobacter pylori.* Methods using PCR alone have been used but have not been validated by EPA. In general, PCR methods are not preferred due to interferences and their inability to demonstrate viability. A combined cultural and molecular method may be considered.
Microsporidia	No suitable method currently available.	No methods are available for the monitoring of the two species of human microsporidia which may have a waterborne route of transmission [*Enterocytozoon bienuesi* and *Encephalitozoon* (formerly *Septata*) *intestinalis*]. Spores could possibly be detected by methods similar to those being developed for *Cryptosporidium parvum.* Potential methods may utilize water filtration, clean-up with IMS, and detection using microscopy with either fluorescent antibody or gene probe procedures. Provided that procedures are validated by EPA, reverse-transcriptase (RT)–PCR techniques may be considered for monitoring, although PCR methods in general are not preferred at this time due to interferences and their inability to demonstrate viability. Due to the small size of microsporida, problems could be encountered during filtration.
Adenoviruses	No suitable method currently available.	Adenoviruses serotypes 1 to 39 and 42 to 47 can be grown in tissue culture but enteric adenoviruses 40 to 41 are difficult to grow. Several selective tissue culture methods and detection methods have been reported. A selective, standardized method is needed for monitoring. PCR methods are not preferred, as they are subject to interferences and do not demonstrate infectivity. A combined cell culture and PCR method may be considered.
Caliciviruses	No suitable method currently available.	No tissue culture methods exist for the two genogroups of caliciviruses on the CCL (the Norwalk-like and the Snow Mountain-like agents). No sensitive or fully developed detection methods exist. PCR methods are not preferred, as they are subject to interferences and do not demonstrate infectivity. A combined cell culture and PCR method may be considered if a suitable cell line is found.

C. Changes to the UCMR Associated With the Screening Survey for List 2 Contaminants

1. Description of Screening Surveys for List 2 Contaminants

The contaminants for which EPA is promulgating new methods are listed in § 141.40(a)(3), Table 1, List 2. Today's rule activates the Screening Survey monitoring for these List 2 contaminants for which methods are being promulgated today. The purpose of the Screening Survey is to analyze for contaminants where the use of newly developed, non-routine analytical methods are required. The Screening Survey approach will allow EPA to maximize scientifically-defensible occurrence data for emerging contaminants of concern more quickly than could be obtained through a more standard unregulated contaminant monitoring effort. The Screening Survey will, for example, be useful in addressing questions concerning whether a contaminant of concern is in fact occurring in drinking water and the range of concentrations of that occurrence. The Screening Survey is also intended to allow EPA to screen contaminants to see if they occur at high enough frequencies or at concentrations that justify inclusion in future unregulated contaminant Assessment Monitoring or at sufficiently low frequencies so that they do not require further monitoring or regulation.

Under today's rule, the Screening Survey for List 2 contaminants will be implemented in two parts: Screening Survey One for chemical contaminants in 2001 at selected small systems and 2002 at selected large systems, and Screening Survey Two for *Aeromonas,* a microbiological contaminant, in 2003 at selected small and large systems.

The contaminants in UCMR (1999) List 2 will be monitored, as part of a Screening Survey, by a smaller, statistically selected sample of 300 systems which represent all (large and small) community and non-transient non-community water systems. As in Assessment Monitoring for List 1 contaminants, public water systems serve as a surrogate for the population potentially affected, and are a more efficient way to develop a sampling approach to estimate exposure to contaminants. These systems have been selected using a random number generator. As discussed in the proposal, EPA will use the data from the Screening Survey as an initial assessment of occurrence to determine whether: (1) More extensive monitoring of a contaminant is warranted (*e.g.,* in the next round of Assessment Monitoring) to determine the need for future regulation; (2) a contaminant

should be eliminated from further consideration for regulation; or, (3) under circumstances of wide-spread occurrence, a contaminant should be moved directly into consideration for regulatory development. EPA will, of course, evaluate other factors and not just this measure of occurrence before deciding to regulate a contaminant.

EPA will pay for the shipping, testing, and reporting for the Screening Survey for systems serving 10,000 or fewer persons. Systems serving 10,000 or fewer persons will be responsible for sample collection and preparing the samples for shipment. EPA will pay for the shipping of these samples to an EPA-designated laboratory for testing and for reporting of monitoring results to EPA, with a copy to the State. Large systems, those serving more than 10,000 persons, must arrange and pay for the monitoring, shipping, testing, and reporting of results.

2. Contaminants and Analytical Methods

In today's final rule, EPA establishes the use of three new EPA methods for the monitoring of 13 chemical contaminants on List 2. These contaminants and methods are listed in Table 2. In addition, EPA has added nitrobenzene to List 2. Methods for two chemical contaminants alachlor ESA and RDX are still being refined and remain reserved on List 2. EPA has moved polonium-210 to List 3. Finally, *Aeromonas* remains reserved for List 2 monitoring (see Table 3). Other pertinent information is listed on Table 4 related to the detection and quantitation for the 13 contaminants to be monitored from List 2. The status of the contaminants and methods are discussed in further detail in this section.

TABLE 4.—DETECTION AND QUANTITATION FOR LIST 2 CONTAMINANTS

	Detection limit	Final MRL [a]
Contaminant:		
2-methylphenol	0.03 µg/L	1 µg/L
2,4,6-trichlorophenol	0.05 µg/L	1 µg/l
2,4-dichlorophenol	0.03 µg/L	1 µg/L
2,4-dinitrophenol	0.3 µg/L	5 µg/L
1,2 diphenylhydrazine	0.03 µg/L	0.5 µg/L
Diazinon	0.02 µg/L	0.5 µg/L
Disulfoton	0.02 µg/L	0.5 µg/L
Fonofos	0.02 µg/L	0.5 µg/L
Prometon	0.04 µg/L	0.5 µg/L
Terbufos	0.02 µg/L	0.5 µg/L
Nitrobenzene	0.01 µg/L	0.5 µg/L
Linuron	0.07 µg/L	1 µg/L
Diuron	0.1 µg/L	1 µg/L
Alachlor ESA and other acetanilide pesticide degradates	Reserved [b]	Reserved [b]
RDX	Reserved [b]	Reserved [b]
Microbiological Contaminant:		
Aeromonas	Reserved [b]	Reserved [b]

[a] Minimum Reporting Level based upon precision and accuracy data derived during methods development and verified in second laboratory validation.
[b] To be determined.

a. New Methods for Use in Screening Survey One

This section includes summaries of the three analytical methods for use for the chemicals included in the Screening Survey in 2001 and 2002. Tables 2 and 3 list the contaminants and new methods. The details of these methods and the results of their peer reviews are documented in Water Docket W–00–01.

(i) *Summary of EPA Method 532.0: Determination of Phenylurea Compounds in Drinking Water by Solid Phase Extraction and High Performance Liquid Chromatography with Ultraviolet Detection.* Today, EPA establishes the use of EPA Method 532.0 to analyze for diuron and linuron. Under this method, a 500 milliliter volume of water is extracted on a chemically bonded C_{18} cartridge or disk, extracted with a small amount of methanol, and the resulting extract injected into a high performance liquid chromatographic (HPLC) system equipped with a C_{18} column and a UV detector. All positive results are confirmed using a second, dissimilar HPLC column.

• *Refinements from Previous Methods.* While linuron and diuron are included in the scope of NPS Method 4 (LLE/HPLC/UV) and EPA Method 553 (SPE/HPLC/MS), these methods were determined to be inappropriate for this monitoring. NPS Method 4 uses mercuric chloride for biological stabilization, does not contain any reagents to reduce disinfectant residuals, and requires the extraction of 1 liter water samples with 180 mL of methylene chloride. EPA Method 553 does not include biological stabilization, and requires the use of a HPLC/MS equipped with a particle beam interface. EPA Method 532, copper sulfate is used to biologically stabilize samples, rather than the toxic compound mercuric chloride, solid phase extraction of 500 mL samples, rather than extracting one liter samples with methylene chloride results in a significant reduction of solvent. In addition, analysis is conducted by performing separation and detection using more commonly available HPLC/UV instrumentation, rather than particle beam interfaces which are no longer manufactured.

(ii) *Summary of EPA Method 528: Determination of Phenols in Drinking Water by Solid Phase Extraction and Capillary Column Gas Chromatography/Mass Spectrometry (GC/MS).* Under this final regulation, EPA requires the use of EPA Method 528 to analyze for 2-methyl-phenol, 2,4,6-trichlorophenol, 2,4-dichlorophenol, and 2,4-dinitrophenol. Under this method, a 1 liter water sample is extracted on a solid phase extraction cartridge containing 0.5 grams of a modified polystyrene divinyl benzene solid phase which is eluted with a small amount of methylene chloride. The resulting extract is then analyzed using a capillary column equipped with GC/MS.

• *Refinements from Previous Methods.* EPA Method 552 lists 2,4-dichlorophenol and 2,4,6-trichlorophenol as an analyte; however,

under the conditions specified, the analytes interfere with one another. Other methods evaluated required the use of techniques that are no longer used in modern laboratories such as large volume solvent extraction, acid, base/neutral fractionation, and were developed for packed column chromatography. In addition, no documentation of either aqueous or extract analyte stability was available.

In EPA Method 528, sample extractions are performed using solid phase extraction without fractionation, capillary column separation without the need to derivatize the analytes, and uses mass spectrometry to reduce false positives. Samples are biologically preserved through acidification and disinfectant residuals are reduced with sodium sulfite.

(iii) *Summary of EPA Method 526: Determination of Selected Semivolatile Organic Compounds in Drinking Water by Solid Phase Extraction and Capillary Column GC/MS.* Under this final regulation, EPA requires the use of EPA Method 526 to analyze for 1,2-diphenylhydrazine, diazinon, disulfoton, fonofos, prometon, nitrobenzene, and terbufos. Under this method, a 1 liter sample is extracted on a chemically bonded styrene divinyl benzene organic phase cartridge or disk. The cartridge or disk is eluted with small quantities of ethyl acetate followed by methylene chloride. The resulting extract is then analyzed on a capillary column equipped GC/MS.

• *Refinements from Previous Methods.* While several of the analytes included in EPA Method 526 are also listed as analytes in EPA Method 507, EPA Method 508, EPA Method 525.2 and other methods, accurate and precise measurement of these analytes in stored samples is not achieved, because of extremely rapid aqueous degradation of these analytes. Literature searches and data collected during methods development of EPA Method 526 demonstrated that many of these analytes are subject to both acid and base catalyzed hydrolysis and that this hydrolysis is also catalyzed by the presence of metals. These compounds are also subject to biological degradation in stored samples, and degradation by free chlorine. In EPA Method 526, reagents are added to all samples to stabilize the analytes. This includes a buffer to neutralize pH, EDTA to complex metals, a biocide to stabilize analytes against biological degradation, and a reagent to reduce disinfectant residuals. Using these reagents, analyte stability has been demonstrated. In addition, all of these reagents can be added to the sample bottles prior to their shipment to the sample collection site.

(iv) *Peer Review.* EPA conducted peer reviews of the analytical methods made final today. The peer reviews were conducted both within EPA and by personnel from Montgomery Watson Laboratories, Philadelphia Suburban Water Company, and the American Water Works Service Company. Summaries of these reviews and EPA responses to them are available at the Water Docket (MC 4101), U.S. EPA, 401 M Street, SW, Washington DC 20460, Docket number W–00–01.

(v) Laboratory Approval and Certification. Laboratories currently certified to conduct drinking water compliance monitoring using EPA Method 525.2 are automatically approved to conduct UCMR analysis using EPA Methods 526 and/or 528. Laboratories currently certified to conduct drinking water compliance monitoring using EPA Methods 549.1 or 549.2, are automatically approved to conduct UCMR analysis using EPA Method 532. As noted earlier, EPA Method 525.2 is a solid phase extraction GC/MS method as are both EPA Methods 526 and 528. EPA Methods 549.1 and 549.2 are solid phase extraction HPLC methods as is EPA Method 532. Using this system of laboratory approval for the UCMR ensures that the laboratories that perform these analysis are currently certified to perform compliance monitoring with methods that use the same technologies as those incorporated in the UCMR methods, while providing PWSs with the widest possible source of approved laboratories.

For small systems, EPA conducted a competitive solicitation to select laboratories to analyze for List 2 contaminants under contract to EPA. All small system shipping and analysis costs will be paid by EPA.

b. Monitoring Nitrobenzene at Low-Level in Screening Survey One

One comment was received on the proposed rule concerning the monitoring of nitrobenzene in both the Assessment and Screening phases of the UCMR. The commentor questioned EPA's retention of a much less sensitive analytical method to test for nitrobenzene under the initial Assessment Monitoring, when nitrobenzene will be measured by a method that is 100 times more sensitive during the Screening (List 2) Monitoring. The commentor added that restricting nitrobenzene to List 2 contaminant monitoring avoids a redundant and costly element in Assessment Monitoring, while providing a statistically significant estimation of occurrence that could, if warranted, trigger more comprehensive monitoring.

EPA believes that nitrobenzene can be reliably and accurately measured at concentrations above 10 μg/L using the purge and trap GC/MS methods approved for use in the Assessment Monitoring phase of the UCMR. Even though currently available preliminary health effects information suggests that nitrobenzene may be of concern at concentrations lower than can be reliably measured using purge and trap GC/MS methods, nitrobenzene was nonetheless included in the monitoring required under Assessment Monitoring since methods reliably measuring nitrobenzene at lower concentrations were not then available. In addition, since the same purge and trap GC/MS methods were being approved of the analyses of other compounds in the assessment phase of the UCMR monitoring, monitoring for nitrobenzene using these methods could be accomplished at very little additional cost to the regulated utilities, States, or EPA. Therefore, EPA felt it was prudent to require this monitoring to obtain valid national occurrence data for this compound.

Since health effects information under current review indicates that nitrobenzene may be of concern at concentrations lower than that measured under Assessment Monitoring, EPA also included nitrobenzene in the list of compounds for which additional methods development was required (List 2 compounds). The analytical method (EPA Method 526) developed for the analyses of diazinon, disulfoton, fonofos, 1,2-diphenylhydrazine, and prometon can also reliably measure nitrobenzene at considerably lower concentrations than can the purge and trap methods approved for the analyses of nitrobenzene under Assessment Monitoring. EPA Method 526 was not available at the time that methods were approved for the Assessment. Therefore, EPA is retaining the required monitoring for nitrobenzene in the Assessment Monitoring phase of the UCMR using the previously approved purge and trap GC/MS methods to collect national monitoring data, but it is also requiring monitoring for nitrobenzene in this Screening Survey phase of the UCMR using EPA Method 526. This will permit the Agency to obtain substantial amounts of occurrence data for nitrobenzene at concentrations above 10 ug/L through UCMR assessment monitoring and a statistically significant estimate of

nitrobenzene at much lower concentrations with the Screening Survey monitoring, and yet not impose additional substantial cost burdens on affected entities. Including nitrobenzene under both Assessment Monitoring and the Screening Survey may also eliminate the need for future UCMR monitoring of nitrobenzene.

c. Monitoring of *Aeromonas* in Screening Survey Two

Under today's action, EPA is approving the proposed monitoring plan for *Aeromonas* as part of Screening Survey Two, to be conducted by 180 small systems and 120 large systems beginning in 2003. Many of the options for monitoring Aeromonas were discussed in the proposed rule published on September 13, 2000 (65 FR 55362). As part of this final rule, EPA is reserving the method for *Aeromonas,* and expects to promulgate EPA Method 1605 in 2001 (briefly summarized below) for monitoring *Aeromonas* for Screening Survey Two.

Analytical Method. The proposed *Aeromonas* spp. method in the proposed rule for List 2 monitoring was EPA Method 1605, which is a membrane filter assay based on the ampicillin-dextrin agar (ADA) method of Havelaar *et al.* (1987), with two additional tests for confirmation: cytochrome oxidase and trehalose fermentation. Proposed EPA Method 1605, ''Determination of *Aeromonas* in Water'', is currently available on-line at *http://www.EPA.gov/nerlcwww/1605sp00.pdf* or by contacting the Safe Drinking Water Hotline at (800) 426–4791; however, the final approval of the method and minimum reporting level will be reserved until promulgated in a subsequent method update rule. This proposed method identifies *Aeromonas* to the genus level and detects *A. hydrophila* and a majority of the other aeromonad species. Laboratories wishing to analyze samples for *Aeromonas* for the UCMR must use the final approved EPA Method 1605 after it is promulgated. *Aeromonas* analyses must be performed by laboratories certified under § 141.28 for compliance analysis of coliform indicator bacteria using an EPA approved membrane filtration procedure. Because of differences between Method 1605 and existing membrane filtration methods, laboratories performing EPA Method 1605 must also participate in performance testing (PT) studies to be conducted by EPA. EPA received five comments regarding performance testing (PT) for *Aeromonas.* EPA has decided once the method is published as final, to require laboratories that analyze samples for *Aeromonas* to participate in a PT program. Laboratories wishing to participate in the *Aeromonas* PT program and be approved must submit a ''request to participate'' letter to EPA. EPA has established a tentative time of late 2001 and early 2002 by which to receive the ''request to participate'' letter, contingent on the publication of the final *Aeromonas* method. EPA will publish further information on the *Aeromonas* PT program for potential participants at the time it promulgates the final method. Any interested laboratory which does not apply for participation or fails to successfully pass the initial PT study but still wishes to support this monitoring, will need to submit a request letter at a later time that will be specified with the promulgation of the final method to be eligible for the second or third PT study. Upon completion of the *Aeromonas* PT Program, EPA will provide each successful laboratory with an approval letter identifying the laboratory by name and the approval date. This letter may then be presented to any Public Water System (PWS) as evidence of laboratory approval for *Aeromonas* analysis supporting the UCMR. Laboratory approval is contingent upon the laboratory maintaining certification to perform drinking water compliance monitoring using an approved coliform membrane filtration method.

EPA Method 1605 identifies *Aeromonas* to the genus level, but does not distinguish between pathogenic and nonpathogenic types. To obtain additional information on *Aeromonas* strains detected with Method 1605, isolates from the ADA plates will be tested for taxonomic characteristics that are associated with pathogenic clinical isolates in follow-up tests conducted by EPA or an EPA contractor. EPA will do these additional analyses for small and large systems that have confirmed positive colonies of *Aeromonas* (see proposed § 141.40(a)(3), Table 1, List 2, footnote j). Confirmed *Aeromonas* colonies must be archived by analytical laboratories performing Method 1605, and shipped to EPA. The Agency will arrange to have additional analyses done on isolates to determine the hybridization groups that are associated with pathogenic forms.

Analytical Method for Determining Hybridization Groups. The phenotypic method described by Abbott *et al.,* (1992) will be used to identify the hybridization group of each isolate. These investigators described a group of biochemical tests that were able to place 132 of 133 *Aeromonas* isolates in the correct hybridization group. The use of biochemical tests to determine hybridization groups of *Aeromonas* is well established (Borrell *et al.,* 1998, Altwegg *et al.,* 1990 and others). EPA may also use restriction fragment length polymorphism (RFLP) for hybridization group identification.

Sampling Times and Locations. As included in EPA's proposal at § 141.40(a)(5)(ii)(B), Table 3, Monitoring Frequency by Contaminant and Water Source Types, EPA is requiring, once the method is promulgated as final, that systems monitoring for *Aeromonas* under Screening Survey Two sample six times during the year, once per quarter during the cooler seasons and once per month during the warmest (vulnerable) quarter, unless the EPA or the State designates a different vulnerable period. This results in one of three sampling schemes: (1) January, April, July, August, September, and October, (2) February, May, July, August, September, and November, or (3) March, June, July, August, September, and December, unless the EPA or State designates a different vulnerable period. Public comments received asked for an option for greater flexibility in setting the sampling schedule for the warmest (vulnerable) month. These sampling times have been revised in response to comments received. At each sample time, three samples must be taken from the distribution system owned or controlled by the PWS selected to monitor. In response to public comments, consecutive systems are no longer included for this monitoring in the distribution system for *Aeromonas.* Sampling locations must include one midpoint in the distribution system where the disinfectant residual will be expected to be typical for the system (midpoint, or MD, as defined in the Rule), and two other points: One of maximum retention time and one where the disinfectant residual will have typically declined (point of maximum residence, or MR, and location of lowest disinfectant residual or LD, respectively, as defined in the Rule). Each sample analyzed for *Aeromonas* will be considered to be an individual data point and will not be averaged with values determined for other samples.

Sites selected for *Aeromonas* samples may utilize locations identified for certain other contaminants which may occur under similar conditions to those described for *Aeromonas.* Sampling for coliform indicator bacteria, which includes midpoint samples, is described in 40 CFR 141.21. Compliance monitoring samples for coliform bacteria are taken from a variety of locations through the distribution system. Some of these samples are from

locations where the disinfectant residual is representative of the distribution system and will not have significantly declined. Locations specified in the sample plan for coliform bacteria that meet this description may be used for the *Aeromonas* midpoint sample. Additionally, a sample must be taken from a location in the distribution system where the disinfectant residual is expected to be low, which is similar to total trihalomethane (TTHM) sample points. Sample locations for TTHMs are described in 63 FR 69468 (1998), the Disinfectants and Disinfection Byproducts Rule, and 40 CFR 141.30. These sample locations must be at distal parts of the distribution system (taking care to avoid disinfectant booster stations) or dead ends, or locations which had previously been determined to have the lowest disinfectant residual. Ground water systems that do not disinfect may utilize the same distal sample locations as those that disinfect. Additional information on *Aeromonas* occurrence in relation to retention time or disinfectant residual are given in Havelaar *et al.,* 1990, Burke *et al.,* 1984, Gavriel *et al.,* 1998, Holmes and Nicolls, 1995. These studies suggest that *Aeromonas* is more likely to occur where the disinfectant residual has declined to less than 0.3 mg/L or where the residence time in the distribution system is longest. Stelzer *et al.* (1992) found *Aeromonas* more commonly at distances greater than 10 km from the treatment plant. Holmes *et al.* (1996) reported after growth of *Aeromonas* in part of a distribution system where the retention time of treated water could exceed 72 hours.

Sample location descriptions for large distribution systems may not be applicable for small systems (or ground water systems that do not disinfect). In the event that the midpoint and distal or low disinfectant residual sample locations described for larger systems do not apply, small systems may use a coliform sample location, and two samples at the farthest point(s) from the source water intake.

Water Quality Parameters Required for Aeromonas Samples. The water quality parameters identified in § 141.40(a)(4)(i)(B), Table 2, Water Quality Parameters to be Monitored with UCMR Contaminants, must be analyzed and reported for the microbiological contaminant on List 2, *Aeromonas,* once its analytical method is final and ready for use. These parameters include water pH, turbidity, temperature, and free and total disinfectant residual.

d. Exclusion of RDX, and Alachlor ESA and Other Acetanilide Pesticide Degradation Products From Monitoring Under Screening Survey at This Time

Not all of the contaminants included in the UCMR (1999) List 2 in the final UCMR Rule (64 FR 50556) are activated for Screening Survey monitoring by this rule. In the proposal for this final rule, EPA identified many important issues, including the development of appropriate analytical methods, that must be resolved before monitoring can be conducted for RDX and Alachlor ESA. The public comments that were received supported the reserve status for these methods and contaminants at this time. The methods for these contaminants (as well as all the List 3 contaminants identified in the September 1999 Revisions to the UCMR) are currently under development and it is not certain when these methods will be completed. If these methods are still in development in December 2001, EPA will consider including these contaminants in the next five-year cycle of UCMR, rather than proposing their methods during this first five-year UCMR cycle.

e. Movement of Polonium-210 From UCMR (1999) List 2 to UCMR (1999) List 3

With today's action, EPA is removing the radionuclide polonium-210 from List 2 of the UCMR (1999) List and moving it to List 3. As discussed in the proposal, many issues still need to be addressed before monitoring is required for this contaminant. Public comments supported moving polonium-210 to List 3. In particular, additional development and validation work is needed before possible methods can be used for routine drinking water analysis. Furthermore, there are laboratory capacity and capability concerns, as an appropriate method for polonium-210 may be very time consuming and will likely require an experienced analyst. Unlike RDX and alachlor ESA, for which analytical methods are available but are being refined, the methods for polonium-210 are not yet at a sufficient point to be used for drinking water analyses, let alone be refined for routine application. Thus, for drinking water analyses, the methods still require development, peer review and EPA approval. As a result, polonium-210 is more appropriately placed on List 3. The movement of polonium-210 from List 2 to List 3 is reflected in § 141.40(a)(3), Table 1, List 3.

3. All List 2 Monitoring at Entry Points to the Distribution System

Today's action also modifies § 141.40(a)(7), which addresses monitoring for List 2 contaminants, to clarify that all List 2 monitoring for chemical contaminants in Screening Survey One must be done at entry points to the distribution system (EPTDS). Public comment supported this approach. The only exception to this requirement for EPTDS sampling is where the EPA or State determines that no treatment or processing is in place between the source water and the EPTDS that would affect measurement of the contaminants involved. Under Assessment Monitoring, systems that routinely sample at source (raw) water sampling points are allowed to sample List 1 contaminants at those points until an unregulated chemical contaminant is found. After such a detection, the system must generally initiate monitoring at the entry points to the distribution system for those contaminants detected. For monitoring for List 2 contaminants, however, EPA believes that allowing such flexibility in sampling locations would jeopardize the consistency of the data generated by the Screening Surveys. Specifically, the revisions to § 141.40(a)(7) specify that List 2 chemical contaminant monitoring must be at the entry point to the distribution system for all systems, to provide for consistent results nationally. In addition, EPA is specifying that List 2 monitoring must be conducted over 1 year (2001 for the first Screening Survey of small systems and 2002 for the first Screening Survey of large systems), rather than any 12 months over the 3-year period, as with List 1 Assessment Monitoring.

4. Implementation

a. Coordination of Assessment Monitoring and Screening Surveys

While EPA has not modified the regulation for coordination of Assessment Monitoring of List 1 and Screening Surveys for List 2, such coordination, to the extent possible, is an important aspect of the UCMR program. For small systems that are required to conduct both Assessment Monitoring and Screening Survey One for chemicals during 2001, the timing and location of sampling will be the same. The one exception will occur for systems that are collecting their Assessment Monitoring samples from source (raw) water sampling points. Sampling locations for Assessment Monitoring and Screening Survey One for chemicals will not coincide for these systems, because all Screening Survey

One samples must be collected from the entry points to the distribution system. Note that not all small systems conducting Assessment Monitoring in 2001 were selected for Screening Survey monitoring, but for those that are, this is clearly indicated in the UCMR State Monitoring Plans for small systems. For large systems serving more than 10,000 persons, the systems randomly selected for Screening Survey One must carry out the monitoring for that survey in 2002.

Assuming the method to analyze for *Aeromonas* is published as final, large and small systems selected for the Screening Survey Two for *Aeromonas* must monitor for that microorganism in 2003. This second Screening Survey does not coincide with Assessment Monitoring from the standpoint of sampling time and location. However, the monitoring for *Aeromonas* is only being conducted at 300 large and small systems in 2003, which has a limited effect on the systems overall. This is a one time, one-year survey, specific to *Aeromonas,* which is being conducted with the expectation that it will provide a nationally consistent result. Figure 1 provides a timeline for implementation of the UCMR, including the Screening Survey for List 2 contaminants.

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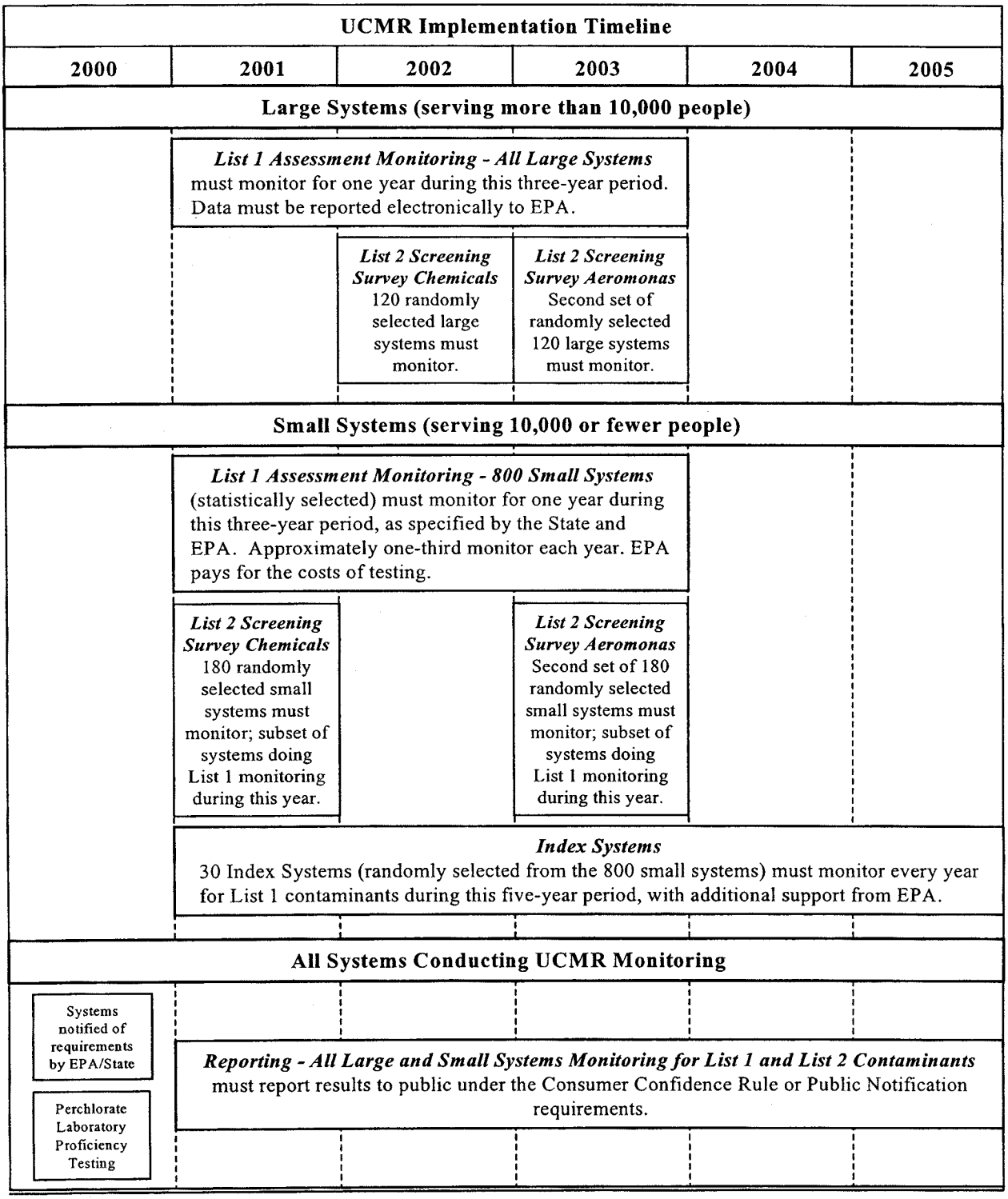
Figure 1

Implementation Timeline for UCMR (1999): Public Water Systems



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b. Selection of Systems by Water Source and Size

EPA selected the systems required to conduct List 2 monitoring from the approximately 2,800 large systems and 800 small systems previously identified by EPA for Assessment Monitoring. One hundred twenty (120) large systems and 180 small systems were randomly selected to monitor for each Screening Survey (i.e., both Screening Survey One for chemicals and Two for *Aeromonas*), approximately based on the following allocation:

System size (persons)	Water source	
	Ground water	Surface water
25–500	30	30
501–3,300	30	30
3,301–10,000	30	30
10,001–50,000	30	30
50,000 or more persons	30	30

This allocation was designed to ensure adequate coverage in both small and large system size and the source water categories. The final selection of Screening Survey systems may vary from this allocation, given the logistical adjustments that some States had to make to their State Monitoring Plans.

c. Sampling Period, Location and Frequency

For small systems serving 10,000 or fewer persons, monitoring for List 2 chemicals is to be conducted in 2001 (Screening Survey One for chemicals), which is also the first year of Assessment Monitoring. EPA will pay for sample shipping, testing, and reporting for small systems. EPA expects to evaluate both the occurrence and the analytical methods used for List 2 contaminants at this time. If adjustments to the methods need to be made before large systems are required to monitor in 2002, EPA has time to make these changes before large systems conduct Screening Survey One monitoring. Large systems serving more than 10,000 persons are required to conduct monitoring in 2002. Once the analytical method is promulgated, the monitoring for *Aeromonas* in Screening Survey Two is to be conducted by all selected small and large systems in 2003.

The sampling location for the chemical contaminants on List 2 is the entry point to the distribution system. For *Aeromonas*, the sampling locations are three places in the distribution system, which is owned or controlled by the selected PWS, representing: (1) A point (midpoint (MD) in the distribution system from § 141.35(d)(3), Table 1) where the disinfectant residual is representative of the distribution system. This sample location may be selected from sample locations which have been previously identified for samples to be analyzed for coliform indicator bacteria. Coliform sample locations are described in 40 CFR 141.21. This same approach must be used for the *Aeromonas* midpoint sample where the disinfectant residual would not have declined and would be typical for the distribution system; (2) The distal or dead-end location in the distribution system (point of maximum retention (MR) furthest from the entry point to the distribution system from § 141.35(d)(3), Table 1), avoiding disinfectant booster stations; and (3) A location where previous determinations have indicated the lowest disinfectant residual in the distribution system (point where the disinfectant residual is lowest (LD) from § 141.35(d)(3), Table 1). If these two locations of distal and low disinfectant residual sites coincide, then the second sample must be taken at a location between the MD and MR sites. Locations in the distribution system where the disinfectant residual is expected to be low are similar to TTHM sampling points. Sampling locations for TTHMs are described in 63 FR 69468.

The frequency of sampling for chemical contaminants on List 2 is the same as for List 1 Assessment Monitoring: four consecutive quarters for surface water systems and two times six months apart for ground water systems, with one of these sampling events (for both water source types) during the vulnerable time specified by EPA in the rule, or by the State in its State Monitoring Plan. For *Aeromonas*, sampling frequency is six times during the year 2003: during the same month (first, second or third month) selected by the system in each quarter, and each month during the warmest quarter (July, August and September, or other vulnerable (warm) period designated by EPA or the State). Additionally, a footnote was added to the year 2003 in column 6 (Table 1, List 2), ''Period During Which Monitoring to be Completed,'' indicating that the monitoring period is contingent on promulgation of the analytical method and minimum reporting level for *Aeromonas*.

d. Sample Analysis

Large systems will sample and send their samples to the EPA certified laboratory of their choice and report the results to EPA as specified in § 141.35. Large systems will pay for the cost of the shipping, testing, and reporting of the results. At small systems, unless the State has agreed to collect the samples for small systems, the owner or operator will collect the sample in EPA-provided equipment. EPA will pay for the shipment, analysis of the samples, and reporting of test results for small systems.

Large systems selected for the Screening Survey will be notified by the State or EPA at least 90 days before the dates established for collecting and submitting samples to determine the presence of contaminants on List 2. One commentor expressed concern over the timing of this notification, noting that systems need adequate time to properly coordinate with contract laboratories. EPA notes that it intends (with assistance from partner States) to provide notification more than 120 days in advance and that 90 days would be the minimum.

e. Reporting

Systems are responsible for reporting the results of UCMR monitoring to EPA, with a copy to the State in a format specified by EPA, through their analytical agent or laboratory, within 30 days following the month in which the results are received from the laboratory. EPA will allow an additional 60 days for system, State, and EPA quality control review before posting the results to the National Drinking Water Contaminant Occurrence Database (NCOD) portion of the Safe Drinking Water Information System. Additionally, EPA has modified the regulation in response to comments about the readiness of the electronic reporting system. Systems will not be required to submit data until September 30, 2001 for the first two quarters of calendar year 2001, but may begin reporting as early as July 1, 2001. EPA has modified § 141.35(c) to reflect this change and provide sufficient time for the reporting system to be ready to accept results.

EPA contract laboratories will generate small system results and will report the data directly into the EPA system. EPA will provide small systems the opportunity to conduct a 30-day quality control review of their results before EPA reports them to the NCOD and before the 60-day quality control review by systems and States. During this 60-day period, EPA will also conduct its own quality control review.

Figures 2 and 3, below, illustrate the UCMR monitoring approach, as well as the timeline for implementation of the first cycle of UCMR monitoring.

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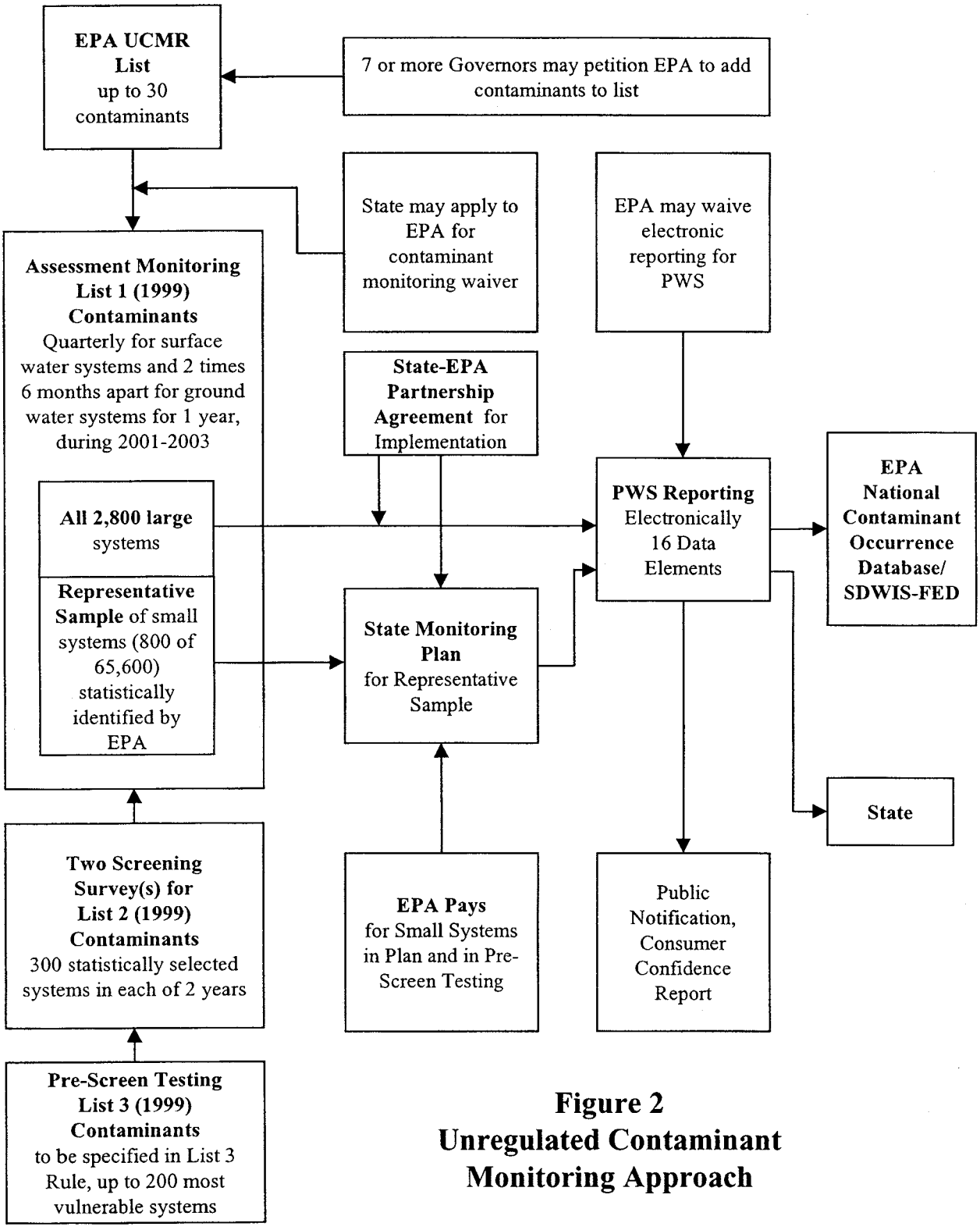
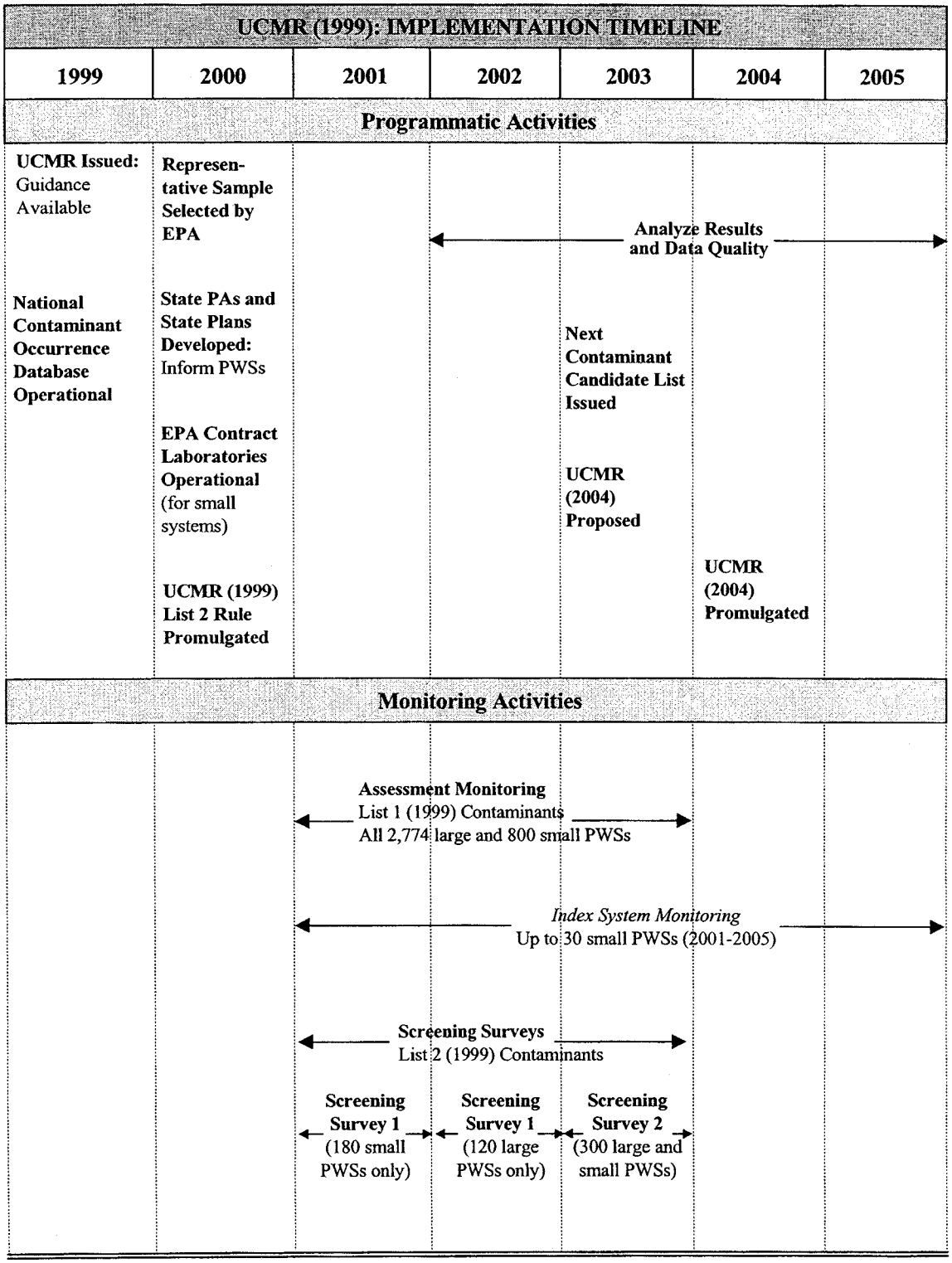


Figure 2
Unregulated Contaminant Monitoring Approach

Figure 3
Implementation Timeline of UCMR (1999) and Related Activities



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D. Other Technical Changes and Clarifications to the UCMR (40 CFR 141.40)

Changes described in this section will affect monitoring and reporting for both List 1 and List 2 contaminants beginning in 2001.

1. Updating the National Drinking Water Contaminant Occurrence Database

EPA modified § 141.35(c) to recognize the updating cycle of the National Drinking Water Contaminant Occurrence Database (NCOD). The existing rule provides for placing the data reported to EPA by systems in the NCOD after a 60-day quality control review period. Today's final rule will continue to provide for the 60-day quality control review by systems, States and the Agency. However, today's rule requires that EPA place the available unregulated contaminant occurrence data resulting from UCMR monitoring in the NCOD at the time of each update of the database, which currently is on the same quarterly update cycle as the Safe Drinking Water Information System. Since updating the databases incurs costs, being able to coordinate this update with an existing update process provides a lower level of expenditure for database maintenance. The NCOD will be updated four times per year, rather than six times. Public comments supported this reporting process. Because these data are for long-term analytical purposes, this change should not inhibit their principal use for regulatory determination and development. The data will still be regularly available to the public through the NCOD. The results of detections of unregulated contaminants is also required to be reported by PWS to consumers through consumer confidence reports.

2. Reporting System and Laboratory Contacts

Section 141.35(d) identifies the data elements to be reported with UCMR contaminant monitoring results. In the process of initiating implementation of the UCMR, including discussions with stakeholders, EPA realized that to facilitate communication in a rule for which EPA had direct implementation responsibility, the agency needed points of contact with public water systems and their analytical agents or organizations (laboratories). In today's final rule, EPA is amending § 141.35(d) to clarify that systems must provide ''point-of-contact'' information. Today's action amends the UCMR to require systems and laboratories to provide the following information: name, mailing address, phone number, and email address for: (1) PWS technical person (i.e., the person at the PWS who is responsible for the technical aspects of UCMR activities, such as details concerning sampling and reporting); (2) PWS official UCMR spokesperson (i.e., the person at the PWS who is able to function as the official spokesperson for the PWS); and (3) laboratory contact person (i.e., the person at the laboratory who is able to address questions concerning the analyses performed). Systems are asked to update this information if it changes during the course of UCMR implementation. The information will be used to facilitate: communication with PWSs and labs regarding any reporting system problems/modifications; resolution of specific data questions; and periodic distribution of any related materials. Public comments supported this technical change.

3. Modification of Data Element Definitions

With today's rule, EPA made minor changes in nine data element definitions, in response to comments received on the final UCMR during implementation workshops and to clarify what is to be reported. These data elements are: PWS facility identification number, sample identification number, sample analysis type, sample batch identification number, analytical precision, analytical accuracy, detection level, detection level unit of measure, and presence/absence. The changes appear in § 141.35, Table 1. The clarifications are as follows:

(a) PWS facility identification sampling point number is now to be a two-part number, made up of the PWS facility identification number and a unique sampling point number within the PWS and assigned by the State, as well as the sampling point type, to allow for relationships between sampling points and other facilities to be reported and maintained, and for appropriate analyses to be made.

(b) Sample identification number has been changed to specify a sample or group of samples that are collected at the same time and place.

(c) Sample analysis type has been modified to address raw and treated field and duplicate samples to ensure that the full range of sample types can be reported.

(d) Sample batch identification number has been changed to clarify that an extraction or an analysis batch number are to be reported along with the laboratory identification number and analysis date.

(e) Analytical accuracy and analytical precision have both been modified to clarify the meaning of each variable identified in the current equations.

(f) EPA modified and eliminated reporting of the detection level and detection level unit of measure to provide additional reporting flexibility. EPA is requiring the reporting of ''minimum reporting level'' and ''minimum reporting level unit of measure,'' in the data elements. PWSs are required to report all detections occurring at or above the minimum reporting level (MRL). Several commentors were concerned about allowing laboratories to establish their own minimum reporting levels (MRL) as long as they are lower than the UCMR MRL for that analyte. Five comments were received questioning the usefulness of data reported below the UCMR MRL and wondered if it would defeat the purpose of setting standardized MRLs. EPA agrees with the commentors and has changed the final regulation to remove the option for reporting of data below the UCMR MRL.

(g) The presence/absence data element is being reserved for potential future use. All of the contaminants currently being monitored can be accurately and precisely quantified. Therefore, their presence or absence does not need to be reported; however, the data element is not deleted. This data element is being reserved for future contaminants to permit the use of presence/absence measured if warranted in future regulations.

Special Note on PWS Facility Identification Number. Table 1 of Section 141.35 previously required that the same PWS Facility Identification Number be used consistently throughout the history of unregulated contaminant monitoring to facilitate analysis of the data. States are already required to number and report to EPA water source intakes and treatment plants, but there is no requirement to hold those numbers static, or even to store them in the State's database. EPA is aware that States converting to the State version of the Safe Drinking Water Information System (SDWIS/STATE) will have new numbers assigned to PWS facilities within that State. Other States converting to other databases during the next several years may face a similar problem. It may be less burdensome on the State to be able to change the number, but the State must report what number the new number is replacing so that SDWIS/FED can link the two for historical tracking. As a result, EPA is including additional flexibility in this definition to allow tracing of historical to current facility identification numbers.

4. Clarification of Data Reporting Procedures

EPA also modified § 141.35 to improve the electronic process that EPA intends to implement for the large amount of data that is expected to be

reported under the UCMR. As EPA evolves its electronic reporting approach Agency-wide, EPA is trying to learn from lessons of such streamlining in the past. Specifically, the electronic reporting that occurred under the Information Collection Rule resulted in a process whereby laboratories entered data electronically using their own formats, provided a hard copy of the report to the public water system, and then the system reentered the data to an electronic disc which was sent to EPA. This resulted in rekeying (data entry) errors and transmission errors, including loss of discs (through mail or damage). EPA is moving toward a ''one-entry'' approach for data reporting. This will improve reporting quality and reduce reporting errors and reduce the time involved in investigating, checking and correcting errors at all levels (laboratory, system, State and EPA). This one-entry approach will make the data more useful and available earlier.

In light of these electronic reporting developments and experiences, EPA modified § 141.35(e) and (f) to clarify its format for reporting and to indicate that a system must instruct the agent or organization that conducts the testing and laboratory analysis for the unregulated contaminants (herein after referred to as ''the laboratory'') to enter the data into the UCMR electronic reporting system. EPA is developing a template for electronically reporting UCMR results to the Agency. The template will allow a PWS regulated by the UCMR to review and approve submission of the results to EPA. The template is being developed in both direct ''batch'' electronic data transfer and web-based ''manual'' entry formats. If the laboratory cannot enter the monitoring results using EPA's direct or manual electronic reporting system, then the PWS must explain to EPA in writing the reasons why alternate reporting is necessary and must receive EPA's approval to use an alternate reporting procedure. To ensure security, laboratories and public water systems will need to register to have access to the UCMR database. Registration will begin after January 16, 2001. EPA will provide systems with information on the registration process. During the PWS registration process, the PWSs will have the opportunity to review and correct relevant PWS inventory information. (Questions may be directed to the Safe Drinking Water Hotline, 1–800–426–4791.)

In addition to reporting analytical results, such data entry also includes the sample collection and PWS information specified in Table 1 of § 141.35.

A public water system has choices for reporting the data to EPA:

(a) The public water system can instruct its analytical agent (laboratory) to electronically report its UCMR results to EPA on the system's behalf. The lab can use either the batch transfer protocol or the web-interface data entry template that EPA will make available over the internet. After the data are submitted by the lab, the PWS can review the results on-line and electronically indicate its approval. Only after the system has submitted the approved data to EPA, and final quality reviews are completed, will the results be available for Agency decision-making or public review.

(b) Systems may require their laboratories to receive their approval before the laboratories report the UCMR results to EPA. In this case, the PWS can review the results prior to the laboratory reporting the data to EPA's electronic reporting system through its own arrangements for receiving data from the laboratory. Typically, the laboratory has already entered the data into its electronic laboratory information management system (LIMS). Once the laboratory receives approval to submit the data from the PWS, it could electronically send the data in batch form from its LIMS to EPA's electronic reporting system.

(c) A system may determine that its laboratory does not have the capability to report electronically (even through entering the data on the web-based screen format) or does not have the capability to provide data to the system prior to submitting it to EPA without rekeying. In this case, the system may submit a request to EPA to use an alternate reporting format.

Under any circumstances, the results must be submitted to EPA within 30 days following the month the PWS receives the results. EPA received comments expressing concern with the reporting deadline relative to the first UCMR sampling in 2001. Commentors were concerned that the new electronic reporting system would not be ready in time for reporting the data that are collected in the first months of 2001, and/or that problems with the initial use of the system would delay reporting. To address the concerns raised by the commentors, EPA has put extra resources toward having the reporting system ready for late January 2001. EPA has also revised the rule to require initial reporting of UCMR data to be done between July 1 and September 30, 2000.

For small water systems, EPA will enter and report the results directly to its electronic reporting system through its contract laboratories. Since the samples, once sent to EPA by the small system, are in EPA's charge, EPA potentially may be required to make the data available to the public if requested prior to the system's review. Again, however, EPA will consider the small system data preliminary and unreliable until the data have undergone quality control review by the system and EPA, and will so inform the public if the Agency is required to release the data before it is reviewed.

This final rule further clarifies that if a PWS chooses to report multiple results for a particular contaminant for the same sampling point and same monitoring event (*i.e.,* date) via the UCMR electronic reporting system, the highest reported value will be used as the official result.

While § 141.35 (b) specifies that the PWS ''must report the results of unregulated contaminant monitoring to EPA *and provide a copy to the State* * * *'', note that States will have electronic access to the monitoring results for State review concurrent with the PWS reporting those results to EPA. Therefore, States may decide to forego the requirement for an independent copy and are free to do so. PWSs should also be aware that some States may have additional requirements (*i.e.,* beyond those specified in this rule), such as immediate reporting of monitoring results which suggest an imminent threat to public health. States are asked to address any additional reporting requirements (or waiver of requirements) when they notify PWSs of their UCMR responsibilities. In the absence of any State direction on this matter, PWSs are expected to provide States with a copy of monitoring results concurrent with reporting those results to EPA via the electronic reporting system.

Additionally, for small systems in States requiring immediate reporting by PWSs of contaminants found in those systems, EPA will report these results to the system and the State promptly after EPA receives the results from its laboratory. In these States, systems still have the responsibility to report the results to the State, regardless of EPA's arrangements to make the data available to the State. Such a State requirement for systems to immediately report any contaminants found is not a requirement on EPA and EPA bears no liability if such reporting is beyond a State's reporting date or if there are errors in the reporting of the information. An example in which reporting results may present a concern to a small system is when EPA sends a paper report to the PWS and the PWS

does not report to the State, and the Agency's electronic process does not recognize the State as a State requiring immediate reporting which precludes the State from obtaining the PWS data from the EPA information system within the time specified by State law.

5. Clarification of Systems Purchasing Water From Other Systems

In § 141.40(a)(1)(ii), the UCMR indicates that large public water systems not purchasing their water from another wholesale or retail public water system must monitor under the requirements outlined in the rule. However, at § 141.40(a)(1)(iii) and (v), it specifies monitoring requirements for large and small public water systems purchasing their water supply from a wholesale public water system only, with no mention of retail systems. Sections 141.40(a)(1)(iii) and (v) have been modified to address both wholesale and retail systems. This technical correction clarifies and provides consistency in regards to wholesale and retail systems in the rule. The original intent was to address purchase of water from another system in these cases, whether or not it was a wholesale or retail system. Additionally, for small systems purchasing their entire water supply, today's rule changes the wording ''wholesale'' to ''another'' public water system to clarify that the selected small system may have to monitor, in particular in the distribution system, regardless of the type of system from which it purchases water. EPA had also proposed to require monitoring for *Aeromonas* in selected consecutive systems. However, stakeholder comments pointed out various problems with conducting such monitoring for Screening Surveys and EPA has modified the final rule to eliminate these systems from monitoring. Only the systems statistically selected and notified must conduct the Screening Survey monitoring for *Aeromonas,* as discussed elsewhere in this Rule.

6. Clarification of Source (Raw) Water Monitoring Alternative

In § 141.40(a)(5)(ii)(C), the UCMR allows systems in States requiring source (raw) water monitoring for compliance monitoring to conduct UCMR monitoring in the source water for List 1 contaminants. However, once one or more contaminants on the UCMR list are found, the monitoring must also be done at the entry points to the distribution system. This final rule establishes that should a system in a State requiring source (raw) water monitoring find a contaminant in the source water, the system must initiate monitoring at the entry point to the distribution system only for the contaminant(s) found, unless it desires to sample and test for all contaminants analyzed by that same method, or for all the contaminants, at its option. EPA has also clarified the rule to specify that the monitoring, once initiated at the entry point to the distribution system, must be conducted for the next 12 month period (four times for surface water systems and two times five to seven months apart for ground water systems), even if the monitoring extends past the end of 2003. This requirement to move the monitoring activity was necessary to allow EPA to assemble a nationally consistent data set for UCMR contaminants.

While this was the original intent, the September 1999 final rule was not clear on this matter. In response to comments, the rule also clarifies (see § 141.40(a)(5)(ii)(C)), however, that EPA or the State may determine that sampling at the entry point to the distribution system is unnecessary because no treatment was instituted between the source water sampling point and the distribution system that would affect measurement of the contaminants involved. Further, if a system would like to guard against the possibility of extending the sampling period then it can take all UCMR samples at the EPTDS. These samples would be separate from compliance monitoring samples for regulated contaminants taken at the source water.

7. Clarification of Treatment Plant Latitude/Longitude Options

At § 141.40(b)(1)(ix), the existing rule states that, if a State enters into a Memorandum of Agreement with EPA to implement the UCMR, the State must report the latitude and longitude of its systems' treatment plants when the systems report the first Assessment Monitoring results for List 1 contaminants. The agency wants to clarify that this requirement under the UCMR is in addition to a preexisting requirement to report by January 1, 2000, either the latitude and longitude or the street address of each treatment plant location. The preexisting reporting requirement is based on 40 CFR 142.15(b)(1) (which requires States to submit inventory information concerning their public water systems, according to a format and schedule prescribed by EPA; the requirement for reporting latitude/longitude information for treatment plants was transmitted to States by memorandum of July 10, 1998, from Robert J. Blanco, Director, Implementation and Assistance Division, OGWDW, as ''Revised Inventory Reporting Requirements for the Safe Drinking Water Information System,'' June 1998, EPA 816–R–98–007, with a reporting date of January 1, 2000) and the EPA Locational Data Policy (published as Information Resources Management Policy Manual 2600, Chapter 13, April 8, 1991). The EPA Locational Data Policy specifies the content of latitude and longitude data that are to be reported by facilities and other entities. The final rule establishes that the State may use the latitude and longitude of closely adjacent facilities at or near the same site, when the facilities are associated with the treatment plant(s). Specifically, the State may use the latitude and longitude of the intake or wellhead/field if the treatment plant is on the same site, or the latitude and longitude of the entry point to the distribution system if it is on the same site as the treatment plant. Other facilities located closely adjacent to the treatment plant and part of the PWS for which it has a latitude and longitude may also be used. As a guide, ''closely adjacent'' should be taken to mean approximately ¼ mile or 400 meters away from the treatment plant or a reasonable location determined by the State. This approach provides the State with the flexibility to use closely associated measurements without having to return to take field measurements. It also provides EPA with the information to be used in health risk assessment relating to the location of contaminants to populations potentially affected. This report of latitude and longitude will be a one-time reporting, unless the information needs to be updated.

8. Addition of Consensus Method for Testing

The 1999 UCMR required systems to arrange for testing of the listed contaminants by a laboratory certified for compliance analysis using specified EPA analytical methods. Since the September 17, 1999, publication of the UCMR, EPA has approved a consensus organization method for compliance monitoring that is also approved for UCMR analysis. Therefore, EPA revised § 141.40(a)(5)(ii)(G), ''Testing'', to allow laboratories certified to perform compliance monitoring using any approved consensus methods that are also approved for UCMR monitoring to be automatically approved to perform UCMR monitoring using that method. The same holds true for any aproved EPA method.

9. Approval of EPA Method 502.2 and Standard Methods 6200C for the Analysis of MTBE

With today's action, in response to comments from stakeholders, EPA is approving the use of EPA Method 502.2 and Standard Methods 6200C for analyses of MTBE, included on List 1 for Assessment Monitoring. Those methods are an addition to those previously identified in § 141.40(a)(3), Table 1, for analysis of MTBE. For systems that want to report MTBE data collected prior to 2001 to meet the UCMR regulatory requirements, they will need to use the UCMR (1999) data elements, as revised by this rule, to meet the reporting requirements of the UCMR. Otherwise, the data will not meet EPA's minimum reporting requirements for UCMR data and will limit the use of the data in subsequent regulatory analyses. This final rule also modifies § 141.40(a)(3), Table 1, List 1, footnote ''n,'' that sample preservation techniques and holding times specified in EPA Method 524.2 must be used by laboratories using either EPA Method 502.2 or Standard Methods 6200C, as the sampling and holding time requirements of Standard Methods 6010B are not adequate for the purposes of the UCMR.

10. Approval of EPA Methods 515.3 and 515.4 for the Analysis of DCPA Mono-acid Degradate and DCPA Di-acid Degradate

In today's final rule, and in response to comments, EPA modified § 141.40(a)(3), Table 1, List 1, to add EPA Methods 515.3 and 515.4 for analysis of DCPA acid metabolites. Adding these methods will provide systems and their laboratories more flexibility in analyzing these UCMR contaminants and managing costs. These methods are an addition to those previously identified in § 141.40(a)(3), Table 1, for analysis of DCPA mono and di-acid degradates. In this rule, EPA also modified § 141.40(a)(3), Table 1, List 1, footnote ''j,'' to permit the use of EPA Method 515.3 for the analysis of DCPA mono-acid and di-acid degradates in the UCMR with the following conditions:

1. When monitoring is conducted using EPA Method 515.3, only the results for DCPA mono-acid and di-acid degradates which are less than the UCMR MRL for these analytes may be reported.

2. If DCPA mono-acid or di-acid degradates are observed at greater than or equal to the UCMR MRL using EPA Method 515.3, then either a duplicate sample must be analyzed within the method specified sample holding time, or a replacement sample, collected within the same month as the original sample, must be analyzed using one of the other methods approved for UCMR analysis of DCPA mono-acid and di-acid degradates. The PWS will then only report the result of subsequent analysis.

EPA also recently developed a revised version of EPA Method 515.3 titled EPA Method 515.4, which includes a wash step following hydrolysis that will remove the parent compound, DCPA. In this rule, EPA is approving the use of EPA Method 515.4 for UCMR monitoring of DCPA mono-acid and di-acid degradates. As this method includes a wash step to remove the parent compound, the use of EPA Method 515.4 is not subject to the conditions described above. EPA may also propose the approval of Method 515.4 for compliance monitoring in a future regulation. Until that time, EPA Method 515.4 is not approved for drinking water compliance monitoring. EPA Method 515.4, ''Determination of Chlorinated Acids in Drinking Water by Liquid-Liquid Extraction, Derivatization and Gas Chromatography with Electron Capture Detection,'' April 2000; EPA #815/B–00/001, is available by requesting a copy from the EPA Safe Drinking Water Hotline within the United States at 800–426–4791 (Hours are Monday through Friday, excluding federal holidays, from 9:00 a.m. to 5:30 p.m. Eastern Time). Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

11. Use of pH as a Water Quality Parameter

Today's final rule also clarifies that pH need not be reported as a water quality parameter for *chemical* contaminants. For the reasons explained in the proposal (65 FR 55362), EPA does not believe that analyzing the pH of finished drinking water will provide relevant data related to the occurrence of these particular UCMR chemical contaminants. Thus, EPA has eliminated pH as a water quality parameter for chemical contaminants. EPA still requires, however, that all the water quality parameters in § 141.40(a)(4)(i)(B), Table 2, Water Quality Parameters to be Monitored with UCMR Contaminants, be reported for microbiological contaminants. The only microbiological contaminant currently required to be monitored under the 1999 UCMR is *Aeromonas,* under Screening Survey Two, to be conducted in 2003, after promulgation of its method.

12. Detection Limit Reference

EPA had proposed to remove the reference to the 40 CFR part 136 appendix B definition of method detection limit (MDL) in the Appendix to § 141.40 and instead to reference the detection limit calculations listed in each method. EPA received three comments on this subject. These commentors support EPA's proposed approach for drinking water. These commentors stated that the requirement to fortify samples for detection limit determination at a level less than or equal to the minimum reporting level (MRL) is a logical simplification and results in significant savings for analytical laboratories on multi-element analyses. While all three of these commentors were strongly in support of the proposed change, two of them also stated that this proposed change should not apply to all programs. Specifically, these commentors stated that the 40 CFR part 136 appendix B concept should continue to be applied to wastewater. These two commentors further stated that the MRL concept used in the UCMR makes sense because there is no meaning attached to levels below the MRL and it is more appropriately based on data quality objectives (DQOs).

EPA agrees with the commentors that the use of the 40 CFR part 136 appendix B MDL concept is not required for purposes of this rule because EPA's goal is to collect analytical data at the MRL or above. The MRL represents a concentration that can be both quantitatively measured and may be of potential health concern. EPA also wishes to affirm the commentors' statements related to the continued application of the 40 CFR part 136 appendix B MDL concept to other programs.

With respect to today's action, EPA is implementing the proposed approach as described in appendix A to § 141.40, paragraph (2). In particular, the regulatory provision in today's final rule requires the calculation of a detection limit, consistent with the procedures described in each respective method for the analyte under consideration. However, the Agency wants to eliminate any potential confusion between this approach and the 40 CFR part 136 appendix B MDL methodology. The approach in today's rule includes other considerations not included in 40 CFR part 136 appendix B, such as requiring the detection limit to be determined over multiple days and not requiring the detection limit samples to be fortified near the calculated detection limit, that may result in a different calculated level

of detection for those analytes measured than would be obtained through use of the procedures described in 40 CFR part 136 appendix B. EPA has determined that the data gathering needs under the UCMR lend themselves to the use of quantitation based limits such as the MRL and less stringent requirements for determination of detection than the needs of other compliance monitoring programs with differing data quality objectives and programmatic requirements.

13. Detection Confirmation

With the addition of an HPLC method for the determination of linuron and diuron, and a proposed membrane filtration method for the analysis of *Aeromonas,* the previous UCMR requirement to confirm all detections by GC/MS can no longer apply to all analyses. Therefore, EPA has modified appendix to § 141.40 to clarify that all detections observed using a gas chromatographic analytical method are to be confirmed by GC/MS, however this confirmation requirement does not apply to analytes detected using a non-gas chromatographic method.

14. Method Defined Quality Control

EPA received questions from representatives of PWS and laboratories concerning the quality control requirements specified for UCMR analyses. EPA has clarified the quality control requirements contained in the appendix to § 141.40 to indicate that by specifying quality control elements specific to UCMR analyses, EPA did not intend to change the methods requirements concerning the analyses of Laboratory Fortified Blanks or Laboratory Performance checks.

15. Clarification of Resampling

EPA offers the following guidance on resampling in response to questions about the 1999 UCMR since its publication in September 1999. If laboratory or shipping problems cause the loss of a sample, then all efforts should be made to replace that sample at the earliest possible time (*i.e.,* resample). EPA's preference is that the sample be replaced within the same month it was originally sampled. If this is not possible, EPA's next preference is within the same quarter. In all but one case, the schedule for future samples should not change: for example, if a surface water PWS is on a sampling schedule of January, April, July, and October and an April sample is lost, it should be resampled as soon as possible (*i.e.,* in April or early May) and the next quarter's samples shall still be taken in July as previously scheduled. The only time this guideline should not be followed is when all the samples from the first sampling period are lost. In this case, the sampling frequency will be determined by when the first set of samples is collected, analyzed and reported: for example, if the plan was to take samples in January, April, July and October, but all the January samples were lost. In such an event, the PWS may decide to resample in February, and its new sampling schedule would become February, May, August and November.

16. Identification of Laboratories Approved for UCMR Monitoring

EPA has received questions from State and PWS representatives regarding the availability of a comprehensive list of laboratories approved to conduct the analysis which support UCMR monitoring. Approval to conduct analysis for the other UCMR contaminants on List 1, Assessment Monitoring and List 2, Screening Survey (chemical monitoring only) relies on existing State or primacy agency laboratory certification for compliance monitoring. For the List 1, Assessment Monitoring contaminants, the existing certifications for methods used in compliance monitoring are directly applicable. For example, a laboratory that has State certification to conduct compliance monitoring in drinking water using EPA Method 525.2 is automatically approved to use that method for UCMR monitoring of any parameter which has EPA Method 525.2 as the UCMR approved method. For the List 2, Screening Survey One for chemical contaminants, the compliance methods and certifications are not directly applicable because none of the approved UCMR List 2 methods are currently used for compliance monitoring. However, the List 2 methods for chemicals are similar (both mechanistically and in terms of the determinative step) to other compliance monitoring methods and consequently, State or primacy agency certification in a specified similar analytical procedure will serve as an approval to conduct these List 2 chemical analyses, as specified in today's rule at § 141.40(a)(5)(ii)(G), ''Testing.'' Following the example cited above, and applying it to the List 2 chemical monitoring, a laboratory with certification to conduct compliance monitoring using EPA Method 525.2 is automatically approved to use EPA Method 526 and 528 to support monitoring for those respective List 2, Screening Survey chemical contaminants. EPA Method 532 is the third approved method for the List 2 chemical contaminants and for this method approval is contingent upon State or primacy agency certification in EPA Method 549.1 or EPA Method 549.2.

For both perchlorate and *Aeromonas* (once EPA promulgates a final analytical method), a laboratory must pass a performance test in addition to using its certification for related methods for approval to analyze and report results for public water systems under the revised UCMR. This is addressed in the rule in § 141.40(a)(5)(G).

EPA does not have a comprehensive or accurate list of laboratories which are currently certified at the State level for drinking water compliance monitoring. Most States have primacy over drinking water compliance issues in their respective State, and laboratory certification is a key component of their State program. If a PWS is attempting to locate a certified laboratory for any of these UCMR analysis, they should first check with the certified laboratory which normally conducts their compliance monitoring. If their regular compliance laboratory does not have the capability or the proper certifications, they should contact their State drinking water administrator to assist in locating an alternate State certified laboratory. Since UCMR monitoring is a direct implementation rule, the PWS could choose a laboratory which has the proper certification for the UCMR approved methods in any other State (several, but not all, of the UCMR perchlorate approved laboratories would qualify). However, if the PWS wishes their UCMR laboratory to provide concurrent compliance monitoring data (*i.e.* Phase II/V) with these UCMR analysis, that alternate laboratory will need to have certification in their respective State.

Currently, the only list of approved laboratories, which has been published by EPA, is specific to the List 1, Assessment Monitoring of perchlorate using EPA Method 314.0 (available at: www.epa.gov/safewater/standard/ucmr/aprvlabs.html). This perchlorate approval is contingent on these labs maintaining their State or primacy agency certification for an inorganic parameter using an approved ion chromatographic compliance monitoring method, and is only granted after these labs have passed the EPA perchlorate PT program.

VI. Additional Issues From Public Comment and EPA Response

Several issues were raised during the public comment processes. EPA received a total of 15 public comments within the specified public comment

period. Other major issues that were addressed that have not been discussed are summarized below.

A. Reporting Data on Other Contaminants

EPA will be paying for the analysis of samples for small systems. The analytical methods used for the List 1 and 2 contaminants will routinely determine the presence of other contaminants for which testing is not required to be done and reported. The contaminants that are not required to be reported but are identified in the analysis of samples from small systems will become research data for EPA and may provide the basis of future Contaminant Candidate Lists. Commentors generally supported collecting such data from small systems (where EPA is conducting the analytical work) but differed on how best to store data in the EPA database. EPA will place these data in the NCOD since they would be considered reliable results for unregulated contaminants under the SDWA and, therefore, must be placed in the NCOD under SDWA Section 1445(g). EPA plans to clearly label these data to indicate that monitoring for these contaminants is not required under this regulation and that reporting under the CCR is not required. Also, because large systems are not included, these data are not completely representative and EPA will not use the data to make a determination to regulate, without supplemental information.

B. More Complete Specification of Contaminants for Unregulated Contaminant Monitoring in the Future

The current approach of listing specific contaminants for monitoring under the UCMR program does not address the complete effect of the individual contaminant on the environment and in drinking water. For example, a pesticide may have several degradates. Unregulated contaminant monitoring only for the parent pesticide may entirely miss potentially harmful degradates and by products. For example, the European Union treats several categories of contaminants as groups for the specification of monitoring requirements, such as ''pesticides and degradates.'' (European Union, 1997). Public comments were mixed on the issue of how to group unregulated contaminants to more completely assess the occurrence of such contaminants in source water and drinking water. The current CCL includes contaminants that are parent compounds, degradates and groups of degradates. EPA will consider the comments received in developing any future proposals for the UCMR. This is a complex topic and further expert and stakeholder discussions may be warranted.

C. Synchronization of UCMR and CCL in the Future

The current schedules for the development of the CCL and UCMR are February 1998 and August 1999, respectively, and then every five years after each of those dates. This scheduling means that the UCMR responds to the contaminant list of the CCL, rather than allowing the UCMR to anticipate contaminants for which the CCL deliberations could evaluate and decide whether or not to regulate. Given the current characteristics of the UCMR program and CCL process, EPA requested public comment on whether the UCMR monitoring list revisions could be promulgated at the same time as the publication of the revised CCL, indicating which contaminants would be on the Lists 1, 2 or 3 about 1½ years earlier than under the current process.

The comments provided a wide range of opinions reflecting the complexity of the issue. While commentors supported some synchronization, they also expressed reservations, noting that the CCL needed to come first to establish the candidate list and priorities. There is no decision on this process and EPA will continue to consider the comments.

VII. Guidance Manuals

EPA will provide guidance manuals to further explain the quality control measures that laboratories are required to perform for List 2 (appendix A to 40 CFR 141.40), as well as all unregulated contaminant monitoring. For small systems that are part of the national representative sample, the sampling guidance, ''Unregulated Contaminant Monitoring Regulation Guidance for Operators of Public Water Systems Serving 10,000 or Fewer Persons'' (EPA 815–R–00–018, December 2000), is available. The ''Unregulated Contaminant Monitoring Regulation Analytical Methods and Quality Control Manual'' (EPA 815–R–99–003, March 2000) and its ''Supplement A to the Unregulated Contaminant Monitoring Regulation Analytical Methods and Quality Control Manual'' (EPA 815–R–00–002, March 2000) are available. These documents are available through the EPA Safe Drinking Water Hotline at 800–426–4791, or through EPA's Office of Ground Water and Drinking Water Homepage at *http://www.epa.gov/safewater.*

VIII. Costs and Benefits of the Rule

A. Program Cost Estimates

Today's amendment to the UCMR (64 FR 50556) adds methods for monitoring the UCMR (1999) List 2 contaminants. The average annual cost for Screening Survey One over the period 2001–2005 is $428,720: EPA, $127,650; States, $0; small systems $120; and large systems, $300,950. The first set of List 2 contaminants may be collected at the same time as the Assessment Monitoring component of the UCMR program. As described elsewhere in this Preamble, the first Screening Survey will be conducted over a 2-year period from 2001 to 2002. One hundred eighty small systems randomly selected from the first 267 small systems monitoring in 2001, and 120 large systems randomly selected from the 2,774 large PWSs will monitor in 2002.

Of the 16 List 2 contaminants, today's rule establishes the analytical methods for 13 chemical contaminants, which will be monitored under Screening Survey One. Today's rule also sets the schedule for the monitoring of *Aeromonas,* which will be monitored under Screening Survey Two once its analytical method is promulgated. Since the method for *Aeromonas* is not being established under today's rule, the estimated costs associated with *Aeromonas* monitoring are not included here, but will be addressed with the promulgation of the final method for *Aeromonas.* Estimated system and EPA costs are based on the analytical costs for these methods. EPA recognizes that these Screening Survey methods are new and will not coincide with other compliance monitoring. However, since the 13 List 2 chemical contaminants for the first Screening Survey may be analyzed by laboratories using water samples that are collected at the same time as the Assessment Monitoring contaminants, there are only minimal incremental labor costs anticipated for systems, in the form of taking an additional sample for List 2 contaminants at the same time of List 1 sampling. The Agency assumes there is minimal added labor burden associated with filling one more sample bottle.

In addition, today's Rule makes several clarifications and technical corrections to the UCMR (1999). EPA believes that none of these clarifications and corrections will increase the costs or labor burden to public water systems or States. Most of these items were already included in the cost and burden analyses for the UCMR (1999); their explanation is simply being clarified. These assumptions are discussed below.

Updating the NCOD on a quarterly basis rather than six times per year will not be an additional expense to systems or States, and will reduce EPA costs marginally. Requiring one-time reporting of system and laboratory points-of-contact will improve the implementation of the program by allowing EPA to convey important testing and reporting information to systems and laboratories, thereby enhancing the long-term data quality. Clarifying the data element definitions will provide more usable information by more clearly conveying the data that should be reported and should not be an additional cost to any entity. Clarifying the data reporting procedures through a ''single-entry'' electronic data reporting process, will reduce costs to systems marginally. Clarification of the source (raw) water monitoring alternative option does not increase the costs to systems beyond those that EPA had anticipated originally in adopting the alternative so that systems in States requiring source water compliance monitoring could coordinate unregulated contaminant monitoring with other monitoring. Providing options for reporting treatment plant latitude and longitude should marginally reduce costs to States which had not previously reported these locational data. Approval of EPA Method 502.2 and Standard Methods 6200C for the analysis of MTBE provides systems more flexibility to use methods that they may already be using to monitor for this unregulated contaminant, possibly providing cost savings to them. Approval of EPA Methods 515.3 and 515.4 for the analysis of DCPA mono-acid degradate and DCPA di-acid degradate provides flexibility to systems to use methods similar to those used in compliance monitoring and may reduce costs for testing and analysis of those unregulated contaminants. Eliminating the use of pH as a water quality parameter required for reporting chemical contaminant results will marginally reduce costs to systems for testing and analysis. Removing the reference to 40 CFR Part 136, Appendix B definition of Minimum Detection Limit is a technical change with no cost. Providing contaminant detection confirmation clarification for linuron and diuron as applying only to non-gas chromatographic methods does not change the costs of the rule for the other unregulated contaminants. This change only applies to these two List 2 contaminants and is included in the cost analysis for the List 2 contaminant methods. Clarifying that the method quality controls for UCMR contaminants are to be used along with the UCMR-specific quality controls for testing and analysis does not increase the cost of the regulation. Finally, clarifying the resampling process when samples must be resubmitted does not increase the cost of the regulation. These costs were included in the original analysis.

As noted, additional non-labor costs from this rule are solely attributed to the laboratory fees that will be charged for analysis of these contaminants. These costs will only be incurred by EPA and by large PWSs. EPA assumes that there will be additional charges imposed for analysis of the List 2 contaminants, since these contaminants will be analyzed under new methods or modifications of existing methods. EPA estimates that the average laboratory fee for the analyses for the 13 Screening Survey One chemical contaminants, using EPA Methods 526, 528, and 532 will be $560. The costs for Screening Survey One for laboratory analyses are calculated as follows: the number of systems multiplied by the number of entry or sampling points, multiplied by the sampling frequency, and then multiplied by the cost of analysis.

IX. Administrative Requirements

A. Executive Order 12866—Regulatory Planning and Review

Under Executive Order 12866 (58 FR 51735, October 4, 1993), the Agency must determine whether a regulatory action is ''significant'' and therefore subject to OMB review and the requirements of the Executive Order. The Order defines ''significant regulatory action'' as one that is likely to result in a rule that may:

(1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or Tribal governments or communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

It has been determined that this rule is not a ''significant regulatory action'' under the terms of Executive Order 12866 and is therefore not subject to OMB review.

B. Executive Order 13045—Protection of Children From Environmental Health Risks and Safety Risks

Executive Order 13045, ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), applies to any rule that: (1) Is determined to be ''economically significant'' as defined under Executive Order 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

This rule is not subject to Executive Order 13045 because it is not ''economically significant'' as defined under Executive Order 12866. Further, this rule does not concern an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. This rule makes only clarifying changes to the September 1999 UCMR and establishes analytical methods and procedures for monitoring of the List 2 unregulated contaminants.

However, this rule is part of the Agency's overall strategy for deciding which contaminants to set drinking water standards for under the Safe Drinking Water Act (see discussion of the Contaminant Candidate List (CCL) at 63 FR 10273). Its purpose is to ensure that EPA obtains data on the occurrence of contaminants on the CCL—specifically, 13 of the List 2 chemical contaminants—where those data are currently lacking. In addition, today's rule sets the schedule for monitoring one microbiological contaminant. The method for this contaminant, *Aeromonas,* is reserved, and will be published in a subsequent notice. EPA is also taking steps to ensure that the Agency will have data on the health effects of these contaminants on children through its research program. The Agency will use these occurrence and health effects data to decide whether to regulate these contaminants.

C. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and Tribal governments and the private sector. Under UMRA section 202, EPA generally must prepare a written

statement, including a cost-benefit analysis, for proposed and final rules with ''Federal mandates'' that may result in expenditures to State, local, and Tribal governments, in the aggregate, or to the private sector, of $100 million or more in any one year. Before promulgating an EPA rule for which a written statement is needed, UMRA section 205 generally requires EPA to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective, or least burdensome alternative that achieves the objectives of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. Moreover, section 205 allows EPA to adopt an alternative other than the least costly, most cost-effective, or least burdensome alternative, if the Administrator publishes with the final rule an explanation of why that alternative was not adopted. Before EPA establishes any regulatory requirements that may significantly or uniquely affect small governments, including Tribal governments, it must have developed under UMRA section 203 a small government agency plan. The plan must provide for notifying potentially affected small governments, enabling officials of affected small governments to have meaningful and timely input in the development of EPA regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements.

EPA has determined that today's rule does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and Tribal governments, in the aggregate, or for the private sector in any one year. Total annual costs of today's rule (across the implementation period of 2001–2005), for State, local, and Tribal governments and the private sector, are estimated to be $428,720, of which EPA will pay $127,650, or approximately 30 percent. Again, States are assumed to incur no additional costs associated with the Screening Survey component of the UCMR. Thus, today's rule is not subject to the requirements of UMRA sections 202 and 205.

EPA has determined that this rule contains no regulatory requirements that might significantly or uniquely affect small governments because EPA will pay for the costs of shipping and sample testing for the small PWSs required to sample and test for unregulated contaminants under this rule, including those owned and operated by small governments. The only thing small governments will have to pay for is the cost of collecting the sample and reviewing the sample result. Screening Survey One samples will generally be collected coincident with Assessment Monitoring and therefore have minimal associated additional burden. These labor costs are minimal. This rule will, therefore, not significantly or uniquely affect small governments. Thus, today's rule is not subject to the requirements of UMRA section 203.

D. Paperwork Reduction Act

The Office of Management and Budget (OMB) has approved the information collection requirements contained in this rule under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* and has assigned OMB control number 2040–0208.

The information to be collected under today's rule fulfills the statutory requirements of section 1445(a)(2) of the Safe Drinking Water Act, as amended in 1996. The data to be collected will describe the source of the water, location of the water source and treatment plant, and test results for samples taken from PWSs. The concentrations of any of the 13 UCMR List 2 contaminants will be evaluated regarding health effects and will be considered for future regulation accordingly. Reporting is mandatory. The data are not subject to confidentiality protection.

The cost estimates described below for the List 2 contaminants are attributed to sampling and additional contract laboratory fees. The additional labor burden that will be incurred by PWSs during the ICR period (2001–2003) for sampling is 100 hours. Screening Survey One sampling will generally be coincident with Assessment Monitoring and the burden and costs for sample collection, packing, and shipping, and reporting were included in the original ICR for the UCMR (1999), except for the small incremental sampling burden of 100 hours. For the first Screening Survey, 180 small water systems (from the national representative sample of systems serving 10,000 or fewer people) will collect and test samples during 2001, and 120 large public water systems will collect and test samples during 2002. It is estimated that each small system will incur an average of 0.06 hours of labor per system per year, with an average labor cost of $1 per system per year. During the ICR period, large systems and EPA will incur costs for the analysis of the 13 List 2 chemical contaminants (e.g., Screening Survey One). Each large system respondent will incur an annual average cost of $4,200. Program implementation costs and burdens for the States, Territories and EPA were already included in the original ICR for UCMR (1999).

EPA will incur no additional labor costs for implementation of today's rule. EPA's annual non-labor costs for the ICR period 2001–2003 are estimated to be $212,700 for Screening Survey One, which consists of 13 chemical contaminants. The non-labor costs are solely attributed to the cost of sample testing by contract laboratories and the shipping of the sample kits to the 180 small systems.

Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and use 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 respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

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. EPA is not amending the table in 40 CFR part 9 of currently approved ICR control numbers. The control number previously approved for UCMR and the approved sections of 40 CFR Part 141 have not been changed.

E. Regulatory Flexibility Act (RFA), as Amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), 5 U.S.C. 601 et seq.

The RFA generally requires an agency to prepare a regulatory flexibility analysis of any rule subject to notice and comment rulemaking requirements under the Administrative Procedure Act or any other statute unless the agency certifies that the rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, small organizations, and small governmental jurisdictions.

The RFA provides default definitions for each type of small entity. It also authorizes an agency to use alternative definitions for each category of small entity, ''which are appropriate to the

activities of the agency'' after proposing the alternative definition(s) in the **Federal Register** and taking comment. 5 U.S.C. 601(3)–(5). In addition to the above, to establish an alternative small business definition, agencies must consult with the Small Business Administration's (SBA) Chief Counsel for Advocacy.

For purposes of assessing the impacts of today's rule on small entities, EPA considered small entities to be systems serving 10,000 or fewer persons. This is the size of system specified in SDWA as requiring special consideration with respect to small system flexibility. In accordance with the RFA requirements, EPA proposed using this alternative definition in the **Federal Register,** (63 FR 7605, February 13, 1998), requested public comment, consulted with SBA on the definition as it relates to small businesses, and expressed its intention to use the alternative definition for all future drinking water regulations in the final Consumer Confidence Reports regulation (63 FR 44511, August 19, 1998). As stated in that final rule, the alternative definition would be applied to regulation, as well.

After considering the economic impacts of today's final rule on small entities, I certify that this action will not have a significant economic impact on a substantial number of small entities. The estimated distribution of the representative sample of small entities required to monitor under today's rule, categorized by ownership type, source water and system size, is presented in Table 1.

TABLE 1.—NUMBER OF PUBLICLY AND PRIVATELY OWNED SYSTEMS TO PARTICIPATE IN SCREENING SURVEY ONE

Size category	Publicly owned systems	Privately owned systems	Total—all systems
Ground Water Systems			
500 and under	8	31	39
501 to 3,300	31	14	45
3,301 to 10,000	24	7	31
Subtotal Ground Water Systems	63	52	115
Surface Water Systems			
500 and under	6	14	20
501 to 3,300	10	5	15
3,301 to 10,000	24	7	30
Subtotal Surface Water Systems	40	26	65
Total	102	78	180

The basis for the UCMR RFA certification for today's rule, which adds the Screening Survey contaminants and methods to the UCMR program, is as follows: The average annual compliance cost of the rule for a small system is $1 which represents 0.0004 percent of revenue/sales for the 180 small systems required to monitor in Screening Survey One as a result of today's rule. In order to reduce burden on small systems, EPA is paying for the costs of analyses, shipping and quality control for all small systems (97% of the entire cost of monitoring and testing by small systems).

F. National Technology Transfer and Advancement Act

As noted in the proposed rule, 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) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so will be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This rulemaking involves technical standards. Therefore, the Agency conducted a search to identify potentially applicable voluntary consensus standards. However, we identified no such standards. Therefore, EPA has decided to use EPA Methods 526, 528, and 532.

G. Executive Order 12898—Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations

Executive Order 12898, ''Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations'' (February 11, 1994), focuses Federal attention on the environmental and human health conditions of minority and low-income populations with the goal of achieving environmental protection for all communities. By seeking to identify unregulated contaminants that may pose health risks via drinking water from all PWSs, today's regulation furthers the protection of public health for all citizens, including minority and low-income populations using public water supplies.

H. Executive Order 13132 (Federalism)

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), 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 does not have federalism implications. It 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. It 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. This Rule specifies the approved analytical methods for 13 List 2 chemical contaminants, thereby allowing these contaminants to be included in the UCMR Screening Survey program, and makes other minor corrections to the September rule (64 FR 50556). The cost to State and local governments is minimal, and the rule does not preempt State law. Thus, Executive Order 13132 does not apply to this rule.

I. Executive Order 13084—Consultation and Coordination With Indian Tribal Governments

Under Executive Order 13084, EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian Tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the Tribal governments, or EPA consults with those governments. If EPA complies by consulting, Executive Order 13084 requires EPA to provide to OMB, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected Tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, Executive Order 13084 requires EPA to develop an effective process permitting elected officials and other representatives of Indian Tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.''

Today's rule does not significantly or uniquely affect the communities of Indian Tribal governments. Only one Tribal water system serves more than 10,000 persons and will be required to monitor and test under this rule. The costs for monitoring and testing for the large system are not significant. All the other Tribal water systems serve 10,000 or fewer persons, and in today's rule had an equal probability of being selected in the national representative sample of small systems. EPA will pay the costs of unregulated contaminant testing for small Tribal water systems just as they will for other small water systems. The actual cost of taking the sample is considered minimal. Tribal water systems will be treated the same as other water systems and the impact of this rule on them will not be significant or unique. There are no costs associated with the minor amendments that clarify the September 1999 UCMR.

This rule will not impose substantial direct compliance costs on Tribal communities either because, with the exception of the one large Tribal water system, the Federal government will provide the funds necessary to pay the potential direct costs incurred by Tribal governments in complying with the rule for the testing and reporting of contaminant occurrence of small systems. By statute, EPA must pay the reasonable testing and laboratory analysis costs for small systems selected to participate in this monitoring program. Accordingly, the requirements of section 3(b) of Executive Order 13084 do not apply to this Rule.

J. Plain Language

Executive Order 12866 and the President's memorandum of June 1, 1998, require each agency to write all rules in plain language. EPA requested comment in the proposed rule on ways to make this rule easier to understand. The Agency did not receive any comments on this matter.

K. Congressional Review Act

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 U.S.C. 804(2). This rule will be effective January 11, 2001.

L. Administrative Procedure Act

Under the Administrative Procedure Act (APA), 5 U.S.C. 553(d), an agency must normally provide a minimum of 30 days between publication of a final rule and its effective date. The effective date for today's rule will be January 11, 2001. Hence, there will be less than 30 days between publication and the effective date. The APA provides that an agency can make a rule effective in less than 30 days, however, where the agency finds ''good cause'' for doing so and publishes the reasons with the rule.

EPA believes that such ''good cause'' exists for making this rule effective in less than 30 days. These reasons are as follows. With respect to List 1 Assessment Monitoring, this is primarily a supplemental rulemaking related to the Unregulated Contaminant Monitoring Regulation (UCMR), that was published on September 17, 1999, and which specified that List 1 monitoring would begin on January 1, 2001. Today's rule does not alter the original effective date for List 1 monitoring but it does make minor revisions to requirements to conducting the monitoring and reporting monitoring results for List 1 contaminants. Because List 1 monitoring has long been scheduled to begin on January 1, 2001, and affected systems have been gearing up to do so, it is critical that all the minor amendments to the original UCMR be effective as soon as possible, so that systems that are scheduled to begin monitoring can do so in compliance with the new requirements.

With respect to List 2 Screening Survey monitoring for 13 contaminants, EPA wants to make this rule effective January 11, 2001, in order to reduce the burden on small systems and allow them to complete their List 2 monitoring coincident with their List 1 Assessment Monitoring.

X. Public Involvement in Regulation Development

EPA's Office of Ground Water and Drinking Water has developed a process for stakeholder involvement in its regulatory activities to provide early input to regulation development. Today's rule amended the September 1999 UCMR, by establishing the method requirements for 13 List 2 chemical contaminants and making other minor changes in the UCMR. At the time of UCMR publication—September 1999—the methods for these contaminants were still being refined by EPA. For a description of public involvement activities related to the UCMR, please see the discussion at 64 FR 50556. EPA conducted a series of five national implementation workshops for States and EPA Regions, regarding the September 1999 UCMR, from March 26 through April 27, 2000, in Philadelphia, Atlanta, Kansas City, Denver, and San Francisco. Participants, other than EPA personnel, represented 35 States, two territories, and one Tribe. Questions about implementation of the UCMR

prompted many of today's technical changes and clarifications.

XI. References

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List of Subjects in 40 CFR Part 141

Environmental protection, Analytical methods, Chemicals, Incorporation by reference, Intergovernmental relations, Microorganisms, Monitoring, Water supply.

Dated: December 15, 2000.

Carol M. Browner,

Administrator.

For the reasons set out in the preamble, title 40, chapter I of the Code of Federal Regulations is amended as follows:

PART 141—NATIONAL PRIMARY DRINKING WATER REGULATIONS

1. The authority citation for part 141 continues to read as follows:

Authority: 42 U.S.C. 300f, 300g–1, 300g–2, 300g–3, 300g–4, 300g–5, 300g–6, 300j–4, 300j–9, and 300j–11.

2. Section 141.35 is amended by:

a. Revising paragraph (c);

b. Revising paragraph (d) (including Table 1);

c. Revising paragraph (e); and

d. Revising paragraph (f).

The Revisions read as follows:

§ 141.35 Reporting of unregulated contaminant monitoring results.

* * * * *

(c) *When must I report monitoring results?* You must report the results of unregulated contaminant monitoring within thirty (30) days following the month in which you received the results from the laboratory. EPA will conduct its quality control review of the data for sixty (60) days after you report the data, which will also allow for quality control review by systems and States. After the quality control review, EPA will place the data in the national drinking water contaminant occurrence database at the time of the next database update. Exception: Reporting of monitoring results to EPA received by public water systems prior to June 30, 2001, must occur between July 1 and September 30, 2001.

(d) *What information must I report?* (1) You must provide the following ''point of contact'' information: name, mailing address, phone number, and e-mail address for:

(i) PWS Technical Contact, the person at your PWS that is responsible for the technical aspects of your unregulated contaminant monitoring regulation (UCMR) activities, such as details concerning sampling and reporting;

(ii) PWS Official, the person at your PWS that is able to function as the official spokesperson for your UCMR activities; and

(iii) Laboratory Contact Person, the person at your laboratory that is able to address questions concerning the analysis that they provided for you.

(2) You must update this information if it changes during the course of UCMR implementation.

(3) You must report the information specified for data elements 1 through 16 in the following table for each sample.

TABLE 1.—UNREGULATED CONTAMINANT MONITORING REPORTING REQUIREMENTS

Data Element	Definition
1. Public Water System (PWS) Identification Number.	The code used to identify each PWS. The code begins with the standard two-character postal State abbreviation; the remaining seven characters are unique to each PWS.
2. Public Water System Facility Identification Number—Sampling Point Identification Number and Sampling Point Type Identification.	The Sampling point identification number and sampling point type identification must either be static or traceable to previous numbers and type identifications throughout the period of unregulated contaminant monitoring. The Sampling point identification number is a three-part alphanumeric designation, made up of:

TABLE 1.—UNREGULATED CONTAMINANT MONITORING REPORTING REQUIREMENTS—Continued

Data Element	Definition
	a. The Public Water System Facility Identification Number is an identification number established by the State, or at the State's discretion the PWS, that is unique to the PWS for an intake for each source of water, a treatment plant, a distribution system, or any other facility associated with water treatment or delivery and provides for the relationship of facilities to each other to be maintained; b. The Sampling Point Identification Number is an identification number established by the State, or at the State's discretion the PWS, that is unique to each PWS facility that identifies the specific sampling point and allows the relationship of the sampling point to other facilities to be maintained; and c. Sampling Point Type Identification is one of following: SR—Untreated water collected at the source of the water system facility. EP—Entry point to the distribution system. MD—midpoint in the distribution system where the disinfectant residual would be expected to be typical for the system such as the location for sampling coliform indicator bacteria as described in 40 CFR 141.21. MR—point of maximum retention is the point located the furthest from the entry point to the distribution system which is approved by the State for trihalomethane (THM) (disinfectant byproducts (DBP)) and/or total coliform sampling. LD—location in the distribution system where the disinfectant residual is the lowest which is approved by the State for THM (DBP) and/or total coliform sampling.
3. Sample Collection Date	The date the sample is collected reported as 4-digit year, 2-digit month, and 2-digit day.
4. Sample Identification Number	An alphanumeric value of up to 15 characters assigned by the laboratory to uniquely identify containers or groups of containers containing water samples collected at the same time and sampling point.
5. Contaminant/Parameter	The unregulated contaminant or water quality parameter for which the sample is being analyzed.
6. Analytical Results—Sign	An alphanumeric value indicating whether the sample analysis result was: a. (<) ''less than'' means the contaminant was not detected or was detected at a level ''less than'' the MRL. b. (=) ''equal to'' means the contaminant was detected at a level ''equal to'' the value reported in ''Analytical Result—Value.''
7. Analytical Result—Value	The actual numeric value of the analysis for chemical and microbiological results, or the minimum reporting level (MRL) if the analytical result is less than the contaminant's MRL.
8. Analytical Result—Unit of Measure	The unit of measurement for the analytical results reported. [e.g., micrograms per liter, (μg/L); colony-forming units per 100 milliliters, (CFU/100 mL), etc.]
9. Analytical Method Number	The identification number of the analytical method used.
10. Sample Analysis Type	The type of sample collected. Permitted values include: a. RFS—Raw field sample—untreated sample collected and submitted for analysis under this rule. b. RDS—Raw duplicate field sample—untreated field sample duplicate collected at the same time and place as the raw field sample and submitted for analysis under this rule. c. TFS—Treated field sample—treated sample collected and submitted for analysis under this rule. d. TDS—Treated duplicate field sample—treated field sample duplicate collected at the same time and place as the treated field sample and submitted for analysis under this rule.
11. Sample Batch Identification Number	The sample batch identification number consists of three parts: a. Up to a 10-character laboratory identification code assigned by EPA. b. Up to a 15-character code assigned by the laboratory to uniquely identify each extraction or analysis batch. c. The date that the samples contained in each extraction batch extracted or in an analysis batch were analyzed, reported as an 8-digit number in the form 4-digit year, 2-digit month, and 2-digit day.
12. Minimum Reporting Level	Minimum Reporting Level (MRL) refers to the lowest concentration of an analyte that may be reported. Unregulated contaminant monitoring (UCM) MRLs are established in §141.40 monitoring requirements for unregulated contaminants.
13. Minimum Reporting Level Unit of Measure	The unit of measure to express the concentration, count, or other value of a contaminant level for the Minimum Reporting Level reported. (e.g., μg/L, colony forming units/100 mL (CFU/100 mL), etc.).
14. Analytical Precision	Precision is the degree of agreement between two repeated measurements and is monitored through the use of duplicate spiked samples. For purposes of the Unregulated Contaminant Monitoring Regulation (UCMR), Analytical Precision is defined as the relative percent difference (RPD) between spiked matrix duplicates. The RPD for the spiked matrix duplicates analyzed in the same batch of samples as the analytical result being reported is to be entered in this field. Precision is calculated as Relative Percent Difference (RPD) of spiked matrix duplicates from the mean using: RPD = absolute value of $[(X_1—X_2) /(X_1 +X_2)/2] \times 100\%$. where: X_1 is the concentration observed in spiked field sample minus the concentration observed in unspiked field sample. X_2 is the concentration observed in duplicate spiked field sample minus the concentration observed in unspiked field sample.

TABLE 1.—UNREGULATED CONTAMINANT MONITORING REPORTING REQUIREMENTS—Continued

Data Element	Definition
15. Analytical Accuracy	Accuracy describes how close a result is to the true value measured through the use of spiked field samples. For purposes of unregulated contaminant monitoring, accuracy is defined as the percent recovery of the contaminant in the spiked matrix sample analyzed in the same analytical batch as the sample result being reported and calculated using: % recovery = [(amt. found in spiked sample—amt. found in sample) − amt. spiked] × 100%.
16. Spiking Concentration	The concentration of method analyte(s) added to a sample to be analyzed for calculating analytical precision and accuracy where the value reported use the same unit of measure reported for Analytical Results.
17. Presence/Absence	Reserved.

(e) *How must I report this information?* (1) You must report results from monitoring under this rule using EPA's electronic reporting system. For quality control purposes, you must instruct the organization(s) responsible for the analysis of unregulated contaminant samples taken under § 141.40 to *enter* the results into the reporting system, in the format specified by EPA. You are responsible for *reviewing* those results and *approving* the reporting (via the electronic system) of the results to EPA. You must also provide a copy of the results to the State, as directed by the State.

(2) If you report more than one set of valid results for the same sampling point and the same sampling event (for example, because you have had more than one organization (*e.g.,* a laboratory) analyze replicate samples collected under § 141.40, or because you have collected multiple samples during a single monitoring event at the same sampling point), EPA will use the highest of the reported values as the official result.

(f) *Does the laboratory to which I send samples report the results for me?* While you must instruct the organization conducting unregulated contaminant analysis (*e.g.,* a laboratory) to enter the results into EPA's electronic reporting system, you are responsible for reviewing and approving the submission of the results to EPA. If the analytical organization or laboratory cannot enter these data for you using EPA's electronic reporting system, then you may explain to EPA in writing the reasons why alternate reporting is necessary and must receive EPA's approval to use an alternate reporting procedure.

* * * * *

3. Section 141.40 is amended by:

a. Revising paragraph (a)(1)(iii) introductory text;

b. Revising paragraph (a)(1)(v) introductory text;

c. Revising Table 1, List 1, List 2 and List 3, in paragraph (a)(3);

d. Revising Table 2, in paragraph (a)(4)(i);

e. Revising paragraph (a)(5)(ii)(B) (including table 3);

f. Revising paragraph (a)(5)(ii)(C);

g. Revising paragraph (a)(5)(ii)(G);

h. Revising paragraphs (a)(7)(i), (ii), and (iii);

i. Revising paragraph (b)(1)(ix);

j. In the Appendix A to § 141.40 by revising paragraphs (2) and (9); and

k. Adding paragraph (11) to the Appendix A to § 141.40.

The revisions and additions read as follows:

§ 141.40 Monitoring requirements for unregulated contaminants.

(a) * * *

(1) * * *

(iii) *Large systems purchasing their entire water supply from another system.* If you own or operate a public water system (other than a transient system) that serves more than 10,000 persons and purchase your entire water supply from a wholesale or retail public water system, you must monitor as follows:

* * * * *

(v) *Small systems purchasing their entire water supply from another system.* If you own or operate a public water system (other than a transient system) that serves 10,000 or fewer persons and purchase your entire water supply from another public water system, you must monitor as follows:

* * * * *

(3) * * *

TABLE 1.—UNREGULATED CONTAMINANT MONITORING REGULATION (1999) LIST

List 1—assessment monitoring chemical contaminants

1-contaminant	2–CAS registry number	3-analytical methods	4-minimum reporting level	5-sampling location	6-period during which monitoring to be completed
2, 4-dinitrotoluene	121–14–2	EPA Method 525.2[a]	2 µg/L[e]	EPTDS[f]	2001–2003
2, 6 dinitrotoluene	606–20–2	EPA Method 525.2[a]	2 µg/L[e]	EPTDS[f]	2001–2003
Acetochlor	34256–82–1	EPA Method 525.2[a]	2 µg/L[o]	EPTDS[f]	2001–2003
DCPA mono-acid degradate[h].	887–54–7	EPA Method 515.1[a], EPA Method 515.2[a], EPA Method 515.3[i,j], EPA Method 515.4[k], D5317–93[b], AOAC 992.32[c].	1 µg/L[e]	EPTDS[f]	2001–2003
DCPA di-acid degradate[h]	2136–79–0	EPA Method 515.1[a], EPA Method 515.2[a], EPA Method 515.3[i,j], EPA Method 515.4[k], D5317–93[b], AOAC 992.32[c].	1 µg/L[e]	EPTDS[f]	2001–2003

TABLE 1.—UNREGULATED CONTAMINANT MONITORING REGULATION (1999) LIST—Continued

List 1—assessment monitoring chemical contaminants					
1-contaminant	2–CAS registry number	3-analytical methods	4-minimum reporting level	5-sampling location	6-period during which monitoring to be completed
4,4′-DDE	72–55–9	EPA Method 508[a], EPA Method 508.1[a], EPA Method 525.2[a], D5812–96[b], AOAC 990.06[c].	0.8 µg/L[e]	EPTDS[f]	2001–2003
EPTC	759–94–4	EPA Method 507[a], EPA Method 525.2[a], D5475–93[b], AOAC 991.07[c].	1 µg/L[e]	EPTDS[f]	2001–2003
Molinate	2212–67–1	EPA Method 507[a], EPA Method 525.2[a], D5475–93[b], AOAC 991.07[c].	0.9 µg/L[e]	EPTDS[f]	2001–2003
MTBE	1634–04–4	EPA Method 502.2[a,n], SM 6200C[d,n], EPA Method 524.2[a], D5790–95[b], SM 6210D[d], SM 6200B[d].	5 µg/L[g]	EPTDS[f]	2001–2003
Nitrobenzene	98–95–3	EPA Method 524.2[a], D5790–95[b], SM6210D[d], SM6200B[d].	10 µg/L[g]	EPTDS[f]	2001–2003
Perchlorate	14797–73–0	EPA Method 314.0[1]	4 µg/L[m]	EPTDS[f]	2001–2003
Terbacil	5902–51–2	EPA Method 507[a], EPA Method 525.2[a], D5475–93[b], AOAC 991.07[c].	2 µg/L[e]	EPTDS[f]	2001–2003

Column headings are:

[1]—Chemical or microbiological contaminant: the name of the contaminants to be analyzed.

[2]—CAS (Chemical Abstract Service Number) Registry No. or Identification Number: a unique number identifying the chemical contaminants.

[3]—Analytical Methods: method numbers identifying the methods that must be used to test the contaminants.

[4]—Minimum Reporting Level: the value and unit of measure at or above which the concentration or density of the contaminant must be measured using the Approved Analytical Methods.

[5]—Sampling Location: the locations within a PWS at which samples must be collected.

[6]—Years During Which Monitoring to be Completed: The years during which the sampling and testing are to occur for the indicated contaminant.

The procedures shall be done in accordance with the documents listed next in these footnotes. The incorporation by reference of the following documents listed in footnotes b-d, i, k and l was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies of the documents may be obtained from the following sources. Information regarding obtaining these documents can be obtained from the Safe Drinking Water Hotline at 800–426–4791. Documents may be inspected at EPA's Drinking Water Docket, 401 M Street, SW., Washington, DC 20460 (Telephone: 202–260–3027); or at the Office of FEDERAL REGISTER, 800 North Capitol Street, NW., Suite 700, Washington, DC.

[a] The version of the EPA methods which you must follow for this Rule are listed at § 141.24 (e).

[b] Annual Book of ASTM Standards, 1996, 1998 and 1999, Vol. 11.02, American Society for Testing and Materials. Method D5812–96, ''Standard Test Method for Determination of Organochlorine Pesticides in Water by Capillary Column Gas Chromatography'', is located in the Annual Book of ASTM Standards, 1998 and 1999, Vol. 11.02. Methods D5790–95, ''Standard Test Method for Measurement of Purgeable Organic Compounds in Water by Capillary Column Gas Chromatography/Mass Spectrometry''; D5475–93, ''Standard Test Method for Nitrogen- and Phosphorus-Containing Pesticides in Water by Gas Chromatography with a Nitrogen-Phosphorus Detector''; and D5317–93, ''Standard Test Method for Determination of Chlorinated Organic Acid Compounds in Water by Gas Chromatography with an Electron Capture Detector'' are located in the Annual Book of ASTM Standards, 1996 and 1998, Vol 11.02. Copies may be obtained from the American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428.

[c] Official Methods of Analysis of AOAC (Association of Official Analytical Chemist) International, Sixteenth Edition, 4th Revision, 1998, Volume I, AOAC International, First Union National Bank Lockbox, PO Box 75198, Baltimore, MD 21275–5198. 800–379–2622.

[d] SM 6210 D is only found in the 18th and 19th editions of Standard Methods for the Examination of Water and Wastewater, 1992 and 1995, American Public Health Association; either edition may be used. SM 6200 B and 6200 C are only found in the 20th edition of Standard Methods for the Examination of Water and Wastewater, 1998. Copies may be obtained from the American Public Health Association, 1015 Fifteenth Street NW, Washington, DC 20005.

[e] Minimum Reporting Level determined by multiplying by 10 the least sensitive method's detection limit (detection limit =standard deviation times the Student's t value for 99% confidence level with n-1 degrees of freedom), or when available, multiplying by 5 the least sensitive method's estimated detection limit (where the estimated detection limit equals the concentration of compound yielding approximately a 5 to 1 signal to noise ratio or the calculated detection limit, whichever is greater).

[f] Entry Points to the Distribution System (EPTDS), after treatment, representing each non-emergency water source in use over the twelve-month period of monitoring: this only includes entry points for sources in operation during the months in which sampling is to occur. Sampling must occur at the EPTDS, unless the State has specified other sampling points that are used for compliance monitoring under 40 CFR 141.24 (f)(1), (2), and (3). See 40 CFR 141.40(a)(5)(ii)(C) for a complete explanation of requirements, including the use of source (raw) water sampling points.

[g] Minimum Reporting Levels (MRL) for Volatile Organic Compounds (VOC) determined by multiplying either the published detection limit or 0.5 µg/L times 10, whichever is greater. The detection limit of 0.5 µg/L (0.0005 mg/L) was selected to conform to VOC detection limit requirements of 40 CFR 141.24(f)(17)(E).

[h] The approved methods do not allow for the identification and quantitation of the individual acids. The single analytical result obtained should be reported as total DCPA mono- and di-acid degradates.

[i] EPA Method 515.3, ''Determination of Chlorinated Acids in Drinking Water by Liquid-Liquid Extraction, Derivatization and Gas Chromatography with Electron Capture Detection,'' Revision 1.0 July 1996. EPA 815-R–00–014, ''Methods for the Determination of Organic and Inorganic compounds in Drinking Water, Volume 1,'' August 2000. Available from the National Technical Information Service, NTIS PB2000–106981, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. The toll free number is 800–553–6847. Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

[J] Since EPA Method 515.3 does not include a solvent wash step following hydrolysis, the parent DCPA is not removed prior to analysis, therefore, only non-detect data may be reported using EPA Method 515.3. All samples with results above the MRL must be analyzed by one of the other approved methods.

[k] EPA Method 515.4, ''Determination of Chlorinated Acids in Drinking Water by Liquid-Liquid Microextraction, Derivatization and Fast Gas Chromatography with Electron Capture Detection,'' Revision 1.0, April 2000, EPA #815/B–00/001. Available by requesting a copy from the EPA Safe Drinking Water Hotline within the United States at 800–426–4791 (Hours are Monday through Friday, excluding federal holidays, from 9 a.m. to 5:30 p.m. Eastern Time). Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

[l] EPA Method 314.0, ''Determination of Perchlorate in Drinking Water Using Ion Chromatography,'' Revision 1.0, EPA 815-B–99–003, November 1999. EPA 815-R–00–014, ''Methods for the Determination of Organic and Inorganic Compounds in Drinking Water, Volume 1,'' August 2000. Available from the National Technical Information Service, NTIS PB2000–106981, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. The toll free number is 800–553–6847. Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

[m] MRL was established at a concentration, which is at least ¼th the lowest known adverse health concentration, at which acceptable precision and accuracy has been demonstrated in spiked matrix samples.

[n] Sample preservation techniques and holding times specified in EPA Method 524.2 must be used by laboratories using either EPA Method 502.2 or Standard Methods 6200C.

List 2—screening survey chemical contaminants

1-contaminant	2-CAS registry number	3-Analytical methods	4-Minimum reporting level	5-sampling location	6-Period during which monitoring to be completed
1,2-diphenylhydrazine	122–66–7	EPA Method 526[a]	0.5 µg/L	EPTDS[e]	2001—Selected Systems serving ≤10,000 persons; 2002—Selected systems serving > 10,000 persons.
2-methyl-phenol	95–48–7	EPA Method 528[b]	1 µg/L[f]	EPTDS[e]	Same as above.
2,4-dichlorophenol	120–83–2	EPA Method 528[b]	1 µg/L[f]	EPTDS[e]	Same as above.
2,4-dinitrophenol	51–28–5	EPA Method 528[b]	5 µg/L[f]	EPTDS[e]	Same as above.
2,4,6-trichlorophenol	88–06–2	EPA Method 528[b]	1 µg/L[f]	EPTDS[e]	Same as above.
Alachlor ESA	Reserved[d]	Reserved[d]	Reserved[d]	Reserved[d]	Reserved[d]
Diazinon	333–41–5	EPA Method 526[a]	0.5 µg/L[f]	EPTDS[e]	2001—Seleected Systems serving ≤10,000 persons; 2002—Selected systems serving > 10,000 persons.
Disulfoton	298–04–4	EPA Method 526[a]	0.5 µg/L[f]	EPTDS[e]	Same as above.
Diuron	330–54–1	EPA Method 532[c]	1 µg/L[f]	EPTDS[e]	Same as above.
Fonofos	944–22–9	EPA Method 526[a]	0.5 µg/L[f]	EPTDS[e]	Same as above.
Linuron	330–55–2	EPA Method 532[c]	1 µg/L[f]	EPTDS[e]	Same as above.
Nitrobenzene	98–95–3	EPA Method 526[a]	0.5 µg/L[f]	EPTDS[e]	Same as above.
Prometon	1610–18–0	EPA Method 526[a]	0.5 µg/L[f]	EPTDS[e]	Same as above.
RDX	121–82–4	Reserved[d]	Reserved[d]	Reserved[d]	Reserved[d].
Terbufos	13071–79-9	EPA Method 526[a]	0.5 µg/L[fK]	EPTDS[e]	2001—Selected Systems serving ≤10,000 persons; 2002-Selected systems serving > 10,000 persons.

List 2—screening survey microbiological contaminants to be sampled after notice of analytical methods availability

1-contaminant	2-identification number	3-analytical methods	4-minimum reporting level	5-sampling location	6-period during which monitoring to be completed
Aeromonas	NA	Reserved[d]	Reserved[d]	Distribution System[g]	2003[h]

Column headings are:

[1]—Chemical or microbiological contaminant: the name of the contaminants to be analyzed.

[2]—CAS (Chemical Abstract Service Number) Registry No. or Identification Number: a unique number identifying the chemical contaminants.

[3]—Analytical Methods: method numbers identifying the methods that must be used to test the contaminants.

[4]—Minimum Reporting Level: the value and unit of measure at or above which the concentration or density of the contaminant must be measured using the Approved Analytical Methods.

[5]—Sampling Location: the locations within a PWS at which samples must be collected.

[6]—Years During Which Monitoring to be Completed: the years during which the sampling and testing are to occur for the indicated contaminant.

The procedures shall be done in accordance with the documents listed next in these footnotes. The incorporation by reference of the following documents listed in footnotes a–c, was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies of the documents may be obtained from the following sources. Information regarding obtaining these documents can be obtained from the Safe Drinking Water Hotline at 800–426–4791. Copies of the documents may be obtained from the sources listed in these footnotes. Information regarding obtaining these documents can be obtained from the Safe Drinking Water Hotline at 800–426–4791. Documents may be inspected at EPA's Drinking Water Docket, 401 M Street, SW., Washington, DC 20460 (Telephone: 202–260–3027); or at the Office of Federal Register, 800 North Capitol Street, NW., Suite 700, Washington, DC.

[a] EPA Method 526, ''Determination of Selected Semivolatile Organic Compounds in Drinking Water by Solid Phase Extraction and Capillary Column Gas Chromatography/Mass Spectrometry (GC/MS),'' Revision 1.0, June 2000. EPA 815–R–00–014, ''Methods for the Determination of Organic and Inorganic Compounds in Drinking Water, Volume 1,'' August 2000. Available from the National Technical Information Service, NTIS PB2000–106981, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. The toll free number is 800–553–6847. Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

[b] EPA Method 528, ''Determination of Phenols in Drinking Water by Solid Phase Extraction and Capillary Column Gas Chromatography/Mass Spectrometry (GC/MS),'' Revision 1.0, April 2000. EPA 815–R–00–014, ''Methods for the Determination of Organic and Inorganic Compounds in Drinking Water, Volume 1,'' August 2000. Available from the National Technical Information Service, NTIS PB2000–106981, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. The toll free number is 800–553–6847. Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/nerlcwww/ordmeth.htm.

[c] EPA Method 532, ''Determination of Phenylurea Compounds in Drinking Water by Solid Phase Extraction and High Performance Liquid Chromatography with UV Detection,'' Revision 1.0, June 2000. EPA 815–R–00–014, ''Methods for the Determination of Organic and Inorganic Compounds in Drinking Water, Volume 1,'' August 2000. Available from the National Technical Information Service, NTIS PB2000–106981, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161. The toll free number is 800–553–6847. Alternatively, the method can be assessed and downloaded directly on-line at www.epa.gov/safewater/methods/sourcalt.html.

[d] To be specified at a later time.

[e] Entry Points to the Distribution System (EPTDS), after treatment, representing each non-emergency water source in use over the twelve-month period of monitoring: this only includes entry points for sources in operation during the months in which sampling is to occur. Sampling must occur at the EPTDS, source water sampling points are not permitted for List 2 contaminant monitoring.

[f] Minimum Reporting Level represents the value of the lowest concentration precision and accuracy determination made during methods development and documented in the method. If method options are permitted, the concentration used was for the least sensitive option.

[g] Three samples must be taken from the distribution system, which is owned or controlled by the selected PWS. The sample locations must include one sample from a point (MD from § 141.35(d)(3), Table 1) where the disinfectant residual is representative of the distribution system. This sample location may be selected from sample locations which have been previously identified for samples to be analyzed for coliform indicator bacteria. Coliform sample locations encompass a variety of sites including midpoint samples which may contain a disinfectant residual that is typical of the system. Coliform sample locations are described in 40 CFR 141.21. This same approach must be used for the *Aeromonas* midpoint sample where the disinfectant residual would not have declined and would be typical for the distribution system. Additionally, two samples must be taken from two different locations: the distal or dead-end location in the distribution system (MR from § 141.35(d)(3), Table 1), avoiding disinfectant booster stations, and from a location where previous determinations have indicated the lowest disinfectant residual in the distribution system (LD from § 141.35(d)(3), Table 1). If these two locations of distal and low disinfectant residual sites coincide, then the second sample must be taken at a location between the MD and MR sites. Locations in the distribution system where the disinfectant residual is expected to be low are similar to TTHM sampling points. Sampling locations for TTHMs are described in 63 FR 69468.

[h] This monitoring period is contingent upon promulgation of the analytical method and minimum reporting level.

List 3—Pre-screen testing radionuclides to be sampled after notice of analytical methods availability

1-contaminant	2-CAS registry number	3-Analytical methods	4-Minimum reporting level	5-Sampling location	6-Period during which monitoring to be completed
Lead-210	14255–04–0	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Polonium-210	13981–52–7	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]

List 3—Pre-screen testing microorganisms to be sampled after notice of analytical methods availability

1-contaminant	2-identification number	3-Analytical methods	4-Minimum reporting level	5-Sampling location	6-Period during which monitoring to be completed
Cyanobacteria (blue-green algae, other freshwater algae and their toxins).	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Echoviruses	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Coxsackieviruses	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Helicobacter pylori	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Microsporidia	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Calciviruses	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]
Adenoviruses	Reserved [a]	Reserved [a]	Reserved [a]	Reserved [a]	Reserved.[a]

Column headings are:

1–Chemical or microbiological contaminant: the name of the contaminants to be analyzed.

2–CAS (Chemical Abstract Service Number) Registry No. or Identification Number: a unique number identifying the chemical contaminants.

3–Analytical Methods: method numbers identifying the methods that must be used to test the contaminants.

4–Minimum Reporting Level: the value and unit of measure at or above which the concentration or density of the contaminant must be measured using the Approved Analytical Methods.

5–Sampling Location: the locations within a PWS at which samples must be collected.

6–Years During Which Monitoring to be Completed: the years during which the sampling and testing are to occur for the indicated contaminant.

[a] To be determined at a later time.

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(4) * * *

(i) * * *

TABLE 2.—WATER QUALITY PARAMETERS TO BE MONITORED WITH UCMR CONTAMINANTS

Parameter	Contaminant type	Analytical methods		
		EPA method	Standard methods [1]	Other
pH	Microbiological	EPA Method 150.1[2], EPA Method 150.2[2].	4500–H^+ B	ASTM D1293–84[3], ASTM D1293–95[3].
Turbidity	Microbiological	EPA Method 180.1 [4,5]	2130 B [4]	GLI Method 2[4,6].

TABLE 2.—WATER QUALITY PARAMETERS TO BE MONITORED WITH UCMR CONTAMINANTS—Continued

Parameter	Contaminant type	Analytical methods		
		EPA method	Standard methods [1]	Other
Temperature	Microbiological		2550.	
Free Disinfectant Residual	Microbiological		4500–Cl D, 4500–Cl F, 4500–Cl G, 4500–Cl H, 4500–ClO_2 D, 4500–ClO_2 E, 4500–O_3 B.	ASTM 1253–86[3]
Total Disinfectant Residual	Microbiological		4500–Cl D, 4500–Cl E,[4] 4500–Cl F, 4500–Cl G[4], 4500–Cl I.	ASTM D 1253–86 [3]

The procedures shall be done in accordance with the documents listed in these footnotes. The incorporation by reference of the following documents was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies of the documents may be obtained from the sources listed in these footnotes. Information regarding obtaining these documents can be obtained from the Safe Drinking Water Hotline at 800–426–4791. Documents may be inspected at EPA's Drinking Water Docket, 401 M Street, SW., Washington, DC 20460 (Telephone: 202–260–3027); or at the Office of Federal Register, 800 North Capitol Street, NW., Suite 700, Washington, DC.

[1] The 18th and 19th Editions of *Standard Methods for the Examination of Water and Wastewater,* 1992 and 1995. Methods 2130 B; 2550; 4500–Cl D, E, F, G, H, I; 4500–ClO_2 D, E; 4500–H^+ B; and 4500–O_3 B in the 20th edition *Standard Methods for the Examination of Water and Wastewater,* 1998, American Public Health Association, 1015 Fifteenth St. NW, Washington D.C., 20005.

[2] EPA Methods 150.1 and 150.2 are available from US EPA, NERL, 26 W. Martin Luther King Dr., Cincinnati, Ohio 45268. The identical methods are also in ''Methods for Chemical Analysis of Water and Wastes,'' EPA–600/4–79–020, March 1983, available from the National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Rd., Springfield, Virginia 22161, PB84–128677. (Note: NTIS toll-free number is 800–553–6847.)

[3] *Annual Book of ASTM Standards,* Editions 1994, 1996, 1998 and 1999, Volumes 11.01, American Society for Testing and Materials, 100 Barr Harbor Drive, West Conshohocken, PA 19428. Version D1293–84, ''Standard Test Methods for pH of Water'' is located in the *Annual Book of ASTM Standards,* 1994, Volumes 11.01. Version D1293–95, ''Standard Test Methods for pH of Water'' is located in the Annual Book of ASTM Standards, 1996, 1998 and 1999, Volumes 11.01.

[4] ''Technical Notes on Drinking Water,'' EPA–600/R–94–173, October 1994, Available at NTIS, PB95–104766.

[5] ''Methods for the Determination of Inorganic Substances in Environmental Samples,'' EPA–600/R–93–100, August 1993. Available at NTIS, PB94–121811

[6] GLI Method 2, ''Turbidity,'' November 2, 1992, Great Lakes Instruments Inc., 8855 North 55th St., Milwaukee, Wisconsin 53223.

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(5) * * *

(ii) * * *

(B) *Frequency.* You must collect the samples within the timeframe and according to the following frequency specified by contaminant type and water source type:

TABLE 3.—MONITORING FREQUENCY BY CONTAMINANT AND WATER SOURCE TYPES

Contaminant type	Water source type	Timeframe	Frequency
Chemical	Surface water	Twelve (12) months	Four quarterly samples taken as follows: Select either the first, second, or third month of a quarter and sample in that same month of each of four (4) consecutive quarters [a] to ensure that one of those sampling events occurs during the vulnerable time.[b]
	Ground water	Twelve (12) months	Two (2) times in a year taken as follows: Sample during one (1) month of the vulnerable time [b] and during one (1) month five (5) to seven (7) months earlier or later.[c]
Microbiological	Surface and ground water	Twelve (12) months	Six (6) times in a year taken as follows: Select either the first, second, or third month of a quarter and sample in that same month of each of four (4) consecutive quarters, and sample an additional 2 months during the warmest (vulnerable) quarter of the year.[d]

[a] ''Select either the first, second, or third month of a quarter and sample in that same month of each of four (4) consecutive quarters'' means that you must monitor during each of the four (4) months of either: January, April, July, October; or February, May, August, November; or March, June, September, December.

[b] ''Vulnerable time'' means May 1 through July 31, unless the State or EPA informs you that it has selected a different time period for sampling as your system's vulnerable time.

[c] ''Sample during one (1) month of the vulnerable time and during one (1) month five (5) to seven (7) months earlier or later'' means, for example, that if you select May as your ''vulnerable time'' month to sample, then one (1) month five (5) to seven (7) months earlier would be either October, November or December of the preceding year, and one (1) month five (5) to seven (7) months later would be either, October, November, or December of the same year.

[d] This means that you must monitor during each of the six (6) months of either: January, April, July, August, September, October; or February, May, July, August, September, November; or March, June, July, August, September, December; unless the State or EPA informs you that a different vulnerable quarter has been selected for your system.

(C) *Location.* You must collect samples at the location specified for each listed contaminant in column 5 of the Table 1, UCMR (1999) List, in paragraph (a)(3) of this section. The sampling location for chemical contaminants must be the entry point to the distribution system or the compliance monitoring point specified by the State or EPA under 40 CFR 141.24 (f)(1), (2), and (3). Except as provided in this paragraph (a)(5)(ii)(C),

if the compliance monitoring point as specified by the State is for source (raw) water and any of the contaminants in paragraph (a)(3) of this section are detected, then you must complete the source water monitoring for the indicated timeframe and also sample at the entry point to the distribution system representative of the affected source water only for the contaminant(s) found in the source water over the next twelve month timeframe, beginning in the next required monitoring period as indicated in paragraph (a)(5)(ii)(B), Table 3 of this section, even though monitoring might extend beyond the last year indicated in column 6, Period during which monitoring to be completed, in Table 1 of paragraph (a)(3). Exception: If the State or EPA determines that sampling at the entry point to the distribution system is unnecessary because no treatment was instituted between the source water and the distribution system that would affect measurement of the contaminants listed in paragraph (a)(3) of this section, then you do not have to sample at the entry point to the distribution system. Note: The sampling for List 2 chemical contaminants must be at the entry point to the distribution system, as specified in Table 1, List 2.

* * * * *

(G) *Testing.* (*1*) Except as provided in paragraph (a)(5)(ii)(G)(*2*) and (*3*) of this section, you must arrange for the testing of the contaminants identified in List 1 of Table 1 by a laboratory certified under § 141.28 for compliance analysis using any of the analytical methods listed in column 3 for each contaminant in List 1 of Table 1, Unregulated Contaminant Monitoring Regulation (1999) List, in paragraph (a)(3) of this section, whether you use the EPA analytical methods or non-EPA methods listed in List 1 of Table 1. Laboratories are automatically certified for the analysis of UCMR contaminants in List 1 of Table 1 if they are already certified to conduct compliance monitoring for a contaminant included in the same method being approved for UCMR analysis.

(*2*) You must arrange for the testing of Perchlorate as identified in List 1 of Table 1 by a laboratory certified under § 141.28 for compliance analysis using an approved ion chromatographic method as listed in § 141.28 and that has analyzed and successfully passed the Performance Testing (PT) Program administered by EPA.

(*3*) You must arrange for the testing of the chemical contaminants identified in List 2 of Table 1 by a laboratory certified under § 141.28 for compliance analysis using EPA Method 525.2 if performing UCMR analysis using EPA Methods 526 or 528, or a laboratory certified under § 141.28 for compliance analysis using EPA Methods 549.1 or 549.2 if performing UCMR analysis using EPA Method 532. You must arrange for the testing for *Aeromonas* using the approved method as identified in List 2 of Table 1 by a laboratory which is both certified under § 141.28 for compliance analysis for coliform indicator bacteria using an EPA approved membrane filtration procedure and which also has been granted approval for UCMR monitoring of *Aeromonas* by successfully passing the *Aeromonas* Performance Testing (PT) Program administered by EPA.

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(*7*) * * *

(i) *All systems.* You must:

(A) Analyze the additional parameters specified in paragraph § 141.40(a)(4)(i), Table 2, ''Water Quality Parameters to be Monitored with UCMR Contaminants'' for each relevant contaminant type. You must analyze the parameters for each sampling event of each sampling point, using the method indicated, and report the results using the data elements 1 through 10 in Table 1, § 141.35(d), Unregulated Contaminant Monitoring Reporting requirements;

(B) Review the laboratory results to ensure reliability; and

(C) Report the results as specified in § 141.35.

(ii) *Large systems.* If your system serves over 10,000 persons, you must collect and arrange for testing of the contaminants in List 2 and List 3 of Table 1, Unregulated Contaminant Monitoring Regulation (1999) List, in paragraph (a)(3) of this section, in accordance with the requirements set out in paragraphs (a)(4) and (5) of this section, with one exception: you must sample only at sampling locations specified in Table 1. You must send the samples to one of the laboratories approved under paragraph (G), this section. You are also responsible for reporting these results as required in § 141.35.

(iii) *Small systems.* If your system serves 10,000 or fewer persons, you must collect samples in accordance with the instructions sent to you by the EPA or State, or, if informed by the EPA or State that the EPA or State will collect the sample, you must assist the State or EPA in identifying the appropriate sampling locations and in taking the samples. EPA will report the results to you and the State.

* * * * *

(b) * * *

(1) * * *

(ix) *Revise system's treatment plant location(s) to include latitude and longitude.* For reporting to the Safe Drinking Water Information System, EPA already requires reporting of either the latitude and longitude or the street address for the treatment plant location. If the State enters into an MOA, the State must report each system's treatment plant location(s) as latitude and longitude (in addition to street address, if previously reported) by the time of the system's reporting of Assessment Monitoring results to the National Drinking Water Contaminant Occurrence Database. The State may use the latitude and longitude of facilities related to the public water system on the same site, or closely adjacent to the same site as the treatment plant, such as the latitude and longitude of the intake or wellhead/field or the entry point to the distribution system, if such measurements are available.

* * * * *

Appendix A to § 141.40—Quality Control Requirements for Testing All Samples Collected

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(2) Detection Limit. Calculate the laboratory detection limit for each contaminant in Table 1, Unregulated Contaminant Monitoring Regulation (1999) List, of paragraph (a)(3) of this section using the appropriate procedure in the specified method with the exception that the contaminant concentration used to fortify reagent water must be less than or equal to the minimum reporting level (MRL) for the contaminants as specified in column 4, Table 1, UCMR (1999) List, in paragraph (a)(3) of this section. The calculated detection limit is equal to the standard deviation times the Student's t value for 99% confidence level with n-1 degrees of freedom. (The detection limit must be less than or equal to one-half of the MRL.)

* * * * *

(9) Detection Confirmation. Confirm any chemical contaminant analyzed using a gas chromatographic method and detected above the MRL, by gas chromatographic/mass spectrometric (GC/MS) methods. If testing resulted in first analyzing the sample extracts via specified gas chromatographic methods, an initial confirmation by a second column dissimilar to the primary column may be performed. If the contaminant detection is confirmed by the secondary column, then the contaminant must be reconfirmed by GC/MS using three (3) specified ion peaks for contaminant identification. Use one of the following confirming techniques: perform single point calibration of the GC/MS system for confirmation purposes only as long as the calibration standard is at a concentration within ± 50% of the concentration determined by the initial analysis; or perform a three (3) point calibration with single point daily calibration verification of the GC/MS

system regardless of whether that verification standard concentration is within ± 50% of sample response. If GC/MS analysis confirms the initial contaminant detection, report results determined from the initial analysis.

* * * * *

(11) Method Defined Quality Control. As appropriate to the method's requirements, perform analysis of Laboratory Fortified Blanks and Laboratory Performance Checks as specified in the method. Each method specifies acceptance criteria for these quality control checks.

[FR Doc. 01–59 Filed 1–10–01; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[OPP–301099; FRL–6762–5]

RIN 2070–AB78

Clopyralid; Pesticide Tolerance

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation amends tolerances for residues of clopyralid (3,6-dichloro-2-pyridinecarboxylic acid) in or on sugar beet roots and sugar beet tops. In addition, this regulation establishes a tolerance for sugar beet molasses. Finally, the established tolerances for barley forage and milled fractions of barley, oats and wheat are being added back to the tolerance expression for clopyralid after being inadvertently deleted. Dow AgroSciences LLC requested this tolerance under the Federal Food, Drug, and Cosmetic Act, as amended by the Food Quality Protection Act of 1996.

DATES: This regulation is effective January 11, 2001. Objections and requests for hearings, identified by docket control number OPP–301099, must be received by EPA on or before March 12, 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 VI. of the **SUPPLEMENTARY INFORMATION.** To ensure proper receipt by EPA, your objections and hearing requests must identify docket control number OPP–301099 in the subject line on the first page of your response.

FOR FURTHER INFORMATION CONTACT: By mail: Joanne I. Miller, Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW.,Washington, DC 20460; telephone number: (703) 305–6224; and e-mail address: miller.joanne@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/. To access the OPPTS Harmonized Guidelines referenced in this document, go directly to the guidelines at http://www.epa.gov/opptsfrs/home/guidelin.htm.

2. *In person.* The Agency has established an official record for this action under docket control number OPP–301099. 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 February 9, 1999 (64 FR 6351) (FRL–6058–3), EPA issued a notice pursuant to section 408 of the Federal Food, Drug, and Cosmetic Act (FFDCA), 21 U.S.C. 346a as amended by the Food Quality Protection Act of 1996 (FQPA) (Public Law 104–170) announcing the filing of a pesticide petition (PP 8F3600) for tolerance by Dow AgroSciences LLC, 9330 Zionsville Road, Indianapolis, IN 46268. This notice included a summary of the petition prepared by Dow AgroSciences LLC, the registrant. There were no comments received in response to the notice of filing.

The petition requested that 40 CFR 180.431 be amended by establishing tolerances for residues of the herbicide clopyralid (3,6-dichloro-2-pyridinecarboxylic acid) in or on sugar beet roots at 2.0 parts per million (ppm), sugar beet tops at 3.0 ppm, and sugar beet molasses at 16.0 ppm.

Section 408(b)(2)(A)(i) of the FFDCA allows EPA to establish a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the tolerance is ''safe.'' Section 408(b)(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....''

EPA performs a number of analyses to determine the risks from aggregate exposure to pesticide residues. For further discussion of the regulatory requirements of section 408 and a complete description of the risk assessment process, see the final rule on Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997) (FRL–5754–7).

III. Aggregate Risk Assessment and Determination of Safety

Consistent with section 408(b)(2)(D), EPA has reviewed the available scientific data and other relevant information in support of this action. EPA has sufficient data to assess the hazards of and to make a determination on aggregate exposure, consistent with section 408(b)(2), for tolerances for residues of clopyralid (3,6-dichloro-2-pyridinecarboxylic acid) on sugar beet roots at 2.0 ppm, sugar beet tops at 3.0 ppm, and sugar beet molasses at 10.0 ppm. EPA's assessment of exposures and risks associated with establishing the tolerance follows.

A. Toxicological Profile

EPA has evaluated the available toxicity data and considered its validity, completeness, and reliability as well as the relationship of the results of the studies 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 nature of the toxic effects caused by clopyralid are discussed in the following Table 1 as well as the no observed adverse effect level (NOAEL) and the lowest observed adverse effect level (LOAEL) from the toxicity studies reviewed.

TABLE 1.—SUBCHRONIC, CHRONIC, AND OTHER TOXICITY

Guideline No.	Study Type	Results
870.3100	90–Day oral toxicity in mice	NOAEL = 2,000 mg/kg/day in both sexes; LOAEL = 5,000 mg/kg/day in both sexes based on decreased body weight in both sexes.
870.3200	21/28–Day dermal toxicity in rabbits	NOAEL ≥1,000 mg/kg/day for both sexes.
870.3250	90–Day dermal toxicity in rats	NA[1]
870.3465	90–Day inhalation toxicity in rats	NA
870.3700a	Prenatal developmental toxicity in rats	Maternal NOAEL = 75 mg/kg/day; LOAEL = 250 mg/kg/day based on mortality, reduced body weight gains and reduced food consumption; Developmental NOAEL ≥250 mg/kg/day
870.3700b	Prenatal developmental toxicity in rabbits	Maternal NOAEL = 110 mg/kg/day; LOAEL = 250 mg /kg/day based on mortality, clinical signs, decreased body weight gains, and lesions of the gastric mucosa; Developmental NOAEL = 110 mg/kg/day; LOAEL = 250 mg/kg/day based on decreased fetal body weight and hydrocephalus
870.3800	Reproduction and fertility effects in rats	Parental/Systemic NOAEL = 500 mg/kg/day for males and females; LOAEL = 1,500 mg/kg/day for males and females based on decreased body weights, decreased weight gain, and decreased food consumption in both sexes and slight focal hyperkeratotic changes in gastric squamous mucosa in males; Reproductive/Offspring NOAEL = 500 mg/kg/day for males and females; LOAEL = 1,500 mg/kg/day for males and females based on reduced pup weights in males and increased relative liver weight in pups of both sexes.
870.4100b	Chronic toxicity in dogs	NOAEL = 100 mg/kg/day in males and females. LOAEL = 320 mg/kg/day based upon reduction in hematological parameters in both sexes, increased absolute liver weight in males, and vacuolated adrenal cortical cells in females.
870.4300	Combined Chronic Toxicity/Carcinogenicity in rats	NOAEL = 15 mg/kg/day in males and females; LOAEL = 150 mg/kg/day based on epithelial hyperplasia and thickening of the limiting ridge of the stomach in both sexes. No evidence of carcinogenicity
870.4200b	Carcinogenicity in mice	NOAEL = 500 mg/kg/day in males and ≥2,000 mg/kg/day in females; LOAEL = 2,000 mg/kg/day in males based on decreased body weight, body weight gains, and food efficiency no evidence of carcinogenicity.
870.5300	*in vitro* and *in vivo* host mediated assay in bacteria	No evidence of induced mutant colonies over background in *Salmonella*strains TA 1,530 and G–46 and *Saccharomyces*strain D–3
870.5385	bone marrow chromosome aberrations assay	There was no significant increase in the frequency of chromosome aberrations in bone marrow at any dose tested.
870.5550	*in vitro* unscheduled DNA synthesis assay	There was no evidence of unscheduled DNA synthesis in initial or supplementary assays.

TABLE 1.—SUBCHRONIC, CHRONIC, AND OTHER TOXICITY—Continued

Guideline No.	Study Type	Results
870.5450	dominant lethal assay in rats.	No evidence of treatment related resorptions up to 400 mg/kg/day for 5 days.
870.6200a	Acute neurotoxicity screening battery in rats	NA
870.6200b	Subchronic neurotoxicity screening battery in rats	NA
870.6300	Developmental neurotoxicity in rats	NA
870.7485	Metabolism in rats	Rapidly absorbed and excreted mainly in the urine. Parent compound only is detected in the excreta.
870.7600	Dermal penetration	NA

[1]Not Applicable

B. Toxicological Endpoints

The dose at which no adverse effects are observed (the NOAEL) from the toxicology study identified as appropriate for use in risk assessment is used to estimate the toxicological level of concern (LOC). However, the lowest dose at which adverse effects of concern are identified (the LOAEL) is sometimes used for risk assessment if no NOAEL was achieved in the toxicology study selected. An uncertainty factor (UF) is applied to reflect uncertainties inherent in the extrapolation from laboratory animal data to humans and in the variations in sensitivity among members of the human population as well as other unknowns. An UF of 100 is routinely used, 10X to account for interspecies differences and 10X for intraspecies differences.

For dietary risk assessment (other than cancer) the Agency uses the UF to calculate an acute or chronic reference dose (acute RfD or chronic RfD) where the RfD is equal to the NOAEL divided by the appropriate UF (RfD = NOAEL/UF). Where an additional safety factor is retained due to concerns unique to the FQPA, this additional factor is applied to the RfD by dividing the RfD by such additional factor. The acute or chronic Population Adjusted Dose (aPAD or cPAD) is a modification of the RfD to accommodate this type of FQPA Safety Factor.

For non-dietary risk assessments (other than cancer) the UF is used to determine the LOC. For example, when 100 is the appropriate UF (10X to account for interspecies differences and 10X for intraspecies differences) the LOC is 100. To estimate risk, a ratio of the NOAEL to exposures (margin of exposure (MOE) = NOAEL/exposure) is calculated and compared to the LOC.

The linear default risk methodology (Q^*) is the primary method currently used by the Agency to quantify carcinogenic risk. The Q^* approach assumes that any amount of exposure will lead to some degree of cancer risk. A Q^* is calculated and used to estimate risk which represents a probability of occurrence of additional cancer cases (e.g., risk is expressed as 1×10^{-6} or one in a million). Under certain specific circumstances, MOE calculations will be used for the carcinogenic risk assessment. In this non-linear approach, a ''point of departure'' is identified below which carcinogenic effects are not expected. The point of departure is typically a NOAEL based on an endpoint related to cancer effects though it may be a different value derived from the dose response curve. To estimate risk, a ratio of the point of departure to exposure (MOE_{cancer} = point of departure/exposures) is calculated. A summary of the toxicological endpoints for clopyralid used for human risk assessment is shown in the following Table 2:

TABLE 2.—SUMMARY OF TOXICOLOGICAL DOSE AND ENDPOINTS FOR CLOPYRALID FOR USE IN HUMAN RISK ASSESSMENT

Exposure Scenario	Dose Used in Risk Assessment, UF	FQPA SF* and Level of Concern for Risk Assessment	Study and Toxicological Effects
Acute Dietary general population including infants and children	NOAEL = 75 mg ai/kg/day; UF = 100; Acute RfD = 0.75 mg ai/ kg/day	FQPA SF = 3X; aPAD = acute RfD/FQPA SF = 0.25 mg/kg/day	Developmental Toxicity Study - rat; Maternal LOAEL = 250 mg ai/kg/day based on decreased weight gain during gestation days 6–9.
Chronic Dietary all populations	NOAEL= 15 mg ai/kg/day; UF = 100; Chronic RfD = 0.15 mg/kg/day	FQPA SF = 3X; cPAD = chronic RfD/FQPA SF = 0.05 mg/kg/day	2–Year Chronic Toxicity/Carcinogenicity Study - rat; LOAEL = 150 mg ai/kg/day based on increased epithelial hyperplasia and thickening of the limiting ridge of the stomach in both sexes.

TABLE 2.—SUMMARY OF TOXICOLOGICAL DOSE AND ENDPOINTS FOR CLOPYRALID FOR USE IN HUMAN RISK ASSESSMENT—Continued

Exposure Scenario	Dose Used in Risk Assessment, UF	FQPA SF* and Level of Concern for Risk Assessment	Study and Toxicological Effects
Short-Term (1–7 days) and Intermediate-Term (1 week - several months) Dermal (Occupational/Residential).	none	No systemic toxicity was seen at the limit dose (1,000 mg/kg/day) in the 21–day dermal toxicity study in rabbits. This risk assessment is not required.	NA
Short-Term (1–7 days) and Intermediate-Term (1 week - several months) Inhalation (Occupational/Residential)	NOAEL= 75 mg ai/kg/day (inhalation absorption rate = 100%)	LOC for MOE = 100 (Occupational); LOC for MOE = 300 (Residential)	Developmental Toxicity Study - rat; Maternal LOAEL = 250 mg ai/kg/day based on decreased body weight gain
Cancer (oral, dermal, inhalation)	''not likely''	NA	Acceptable oral rat and mouse carcinogenicity studies; no evidence of carcinogenic or mutagenic potential.

UF = uncertainty factor, FQPA SF = FQPA safety factor, NOAEL = no observed adverse effect level, LOAEL = lowest observed adverse effect level, PAD = population adjusted dose (a = acute, c = chronic), RfD = reference dose, MOE = margin of exposure, LOC = level of concern.
*The reference to the FQPA Safety Factor refers to any additional safety factor retained of concerns unique to the FQPA.

C. Exposure Assessment

1. *Dietary exposure from food and feed uses.* Tolerances have been established (40 CFR 180.431) for the residues of clopyralid, in or on a variety of raw agricultural commodities. Risk assessments were conducted by EPA to assess dietary exposures from clopyralid (3,6-dichloro-2-pyridinecarboxylic acid) in food as follows:

i. *Acute exposure.* Acute dietary risk assessments are performed for a food-use pesticide if a toxicological study has indicated the possibility of an effect of concern occurring as a result of a one day or single exposure. The Dietary Exposure Evaluation Model (DEEM®) analysis evaluated the individual food consumption as reported by respondents in the USDA 1989–1992 nationwide Continuing Surveys of Food Intake by Individuals (CSFII) and accumulated exposure to the chemical for each commodity. The following assumptions were made for the acute exposure assessments: For all commodities, 100% crop treated was assumed and those residues will be at the level of the tolerance (with one exception: refined sugar from sugar-beet). The above assumptions result in an overestimate of human dietary exposure. All Section 18 tolerances (canola, cranberries, flax seed, peaches, and nectarines) are included in this dietary risk assessment. With the exception of sugar beets, default processing factors were used for processed commodities. The empirical processing factor of 0.1X was used for sugar-beet representing the 10-fold reduction in residues for refined sugar. The aPAD for the U.S. population is 0.25 mg/kg/day. For acute dietary risk estimates, the level of concern is >100% aPAD. The population subgroup with the highest dietary exposure from food is children 1–6 years. The percentage of dietary exposure for this subgroup is 13% of the aPAD. The acute dietary risk estimates from residues in food which result from the established and proposed uses of clopyralid are below the level of concern for the U.S. population and all population subgroups.

ii. *Chronic exposure.* In conducting this chronic dietary risk assessment the Dietary Exposure Evaluation Model (DEEM) analysis evaluated the individual food consumption as reported by respondents in the USDA 1989–1992 nationwide Continuing Surveys of Food Intake by Individuals (CSFII) and accumulated exposure to the chemical for each commodity. The following assumptions were made for the chronic exposure assessments: For all commodities, 100% crop treated was assumed and those residues will be at the level of the tolerance (with one exception: refined sugar from sugar-beet). The empirical processing factor of 0.1X was used for sugar-beet representing the 10-fold reduction in residues for refined sugar. The cPAD for the general U.S. population and all subgroups is 0.05 mg/kg/day. For chronic dietary risk estimates, the Agency's level of concern is greater than 100% of the cPAD. The subgroup with the highest chronic dietary exposure from food is children 1–6 years. The percentage of dietary exposure for this subgroup is 34% of the cPAD. The chronic dietary risk estimates from residues in food resulting from the established and proposed uses of clopyralid are below the Agency's level of concern for the U.S. population and all population subgroups.

iii. *Cancer.* The Agency concluded that clopyralid was negative for carcinogenic potential in mice and rats and classified clopyralid as ''not likely'' to be a human carcinogen. Therefore, a cancer dietary exposure analysis was not performed.

iv. *Anticipated residue and percent crop treated information.* Section 408(b)(2)(E) authorizes EPA to use available data and information on the anticipated residue levels of pesticide residues in food and the actual levels of pesticide chemicals that have been measured in food. If EPA relies on such information, EPA must require that data be provided 5 years after the tolerance is established, modified, or left in effect, demonstrating that the levels in food are not above the levels anticipated. Following the initial data submission, EPA is authorized to require similar data on a time frame it deems appropriate. As required by section 408(b)(2)(E), EPA will issue a data call-in for information relating to anticipated residues to be submitted no later than 5 years from the date of issuance of this tolerance.

2. *Dietary exposure from drinking water.* The Agency lacks sufficient monitoring exposure data to complete a comprehensive dietary exposure analysis and risk assessment for clopyralid in drinking water. Because the Agency does not have comprehensive monitoring data,

drinking water concentration estimates are made by reliance on simulation or modeling taking into account data on the physical characteristics of clopyralid.

The Agency uses the Generic Estimated Environmental Concentration (GENEEC) or the Pesticide Root Zone/ Exposure Analysis Modeling System (PRZM/EXAMS) to estimate pesticide concentrations in surface water and SCI-GROW, which predicts pesticide concentrations in groundwater. In general, EPA will use GENEEC (a tier 1 model) before using PRZM/EXAMS (a tier 2 model) for a screening-level assessment for surface water. The GENEEC model is a subset of the PRZM/ EXAMS model that uses a specific high-end runoff scenario for pesticides. GENEEC incorporates a farm pond scenario, while PRZM/EXAMS incorporate an index reservoir environment in place of the previous pond scenario. The PRZM/EXAMS model includes a percent crop area factor as an adjustment to account for the maximum percent crop coverage within a watershed or drainage basin.

None of these models include consideration of the impact processing (mixing, dilution, or treatment) of raw water for distribution as drinking water would likely have on the removal of pesticides from the source water. The primary use of these models by the Agency at this stage is to provide a coarse screen for sorting out pesticides for which it is highly unlikely that drinking water concentrations would ever exceed human health levels of concern.

Since the models used are considered to be screening tools in the risk assessment process, the Agency does not use estimated environmental concentrations (EECs) from these models to quantify drinking water exposure and risk as a %RfD or %PAD. Instead, drinking water levels of comparison (DWLOCs) are calculated and used as a point of comparison against the model estimates of a pesticide's concentration in water. DWLOCs are theoretical upper limits on a pesticide's concentration in drinking water in light of total aggregate exposure to a pesticide in food, and from residential uses. Since DWLOCs address total aggregate exposure to clopyralid they are further discussed in the aggregate risk sections below.

Based on the GENEEC and SCI-GROW models the estimated environmental concentrations (EECs) of clopyralid for acute exposures are estimated to be 27.0 parts per billion (ppb) for surface water and 9.7 ppb for ground water. The EECs for chronic exposures are estimated to be 9 ppb for surface water, (based on a 56–day concentration of 27 ppb and a 3x adjustment factor allowed by Agency policy for 56–day GENEEC values) and 9.7 ppb for ground water.

3. *From non-dietary exposure*. The term ''residential exposure'' is used in this document to refer to non-occupational, non-dietary exposure (e.g., for lawn and garden pest control, indoor pest control, termiticides, and flea and tick control on pets).

Clopyralid is currently registered for use on the following residential non-dietary sites: Turf and ornamentals (including golf courses). The risk assessment was conducted using the following residential exposure assumptions: the 75 mg/kg/day NOAEL was used in the inhalation, short-term, and intermediate-term hand-to-mouth, and episodic granular ingestion risk assessments of the residential exposure. As no dermal endpoint was selected, a dermal risk assessment was not required for residential exposure. For residential oral and inhalation risk assessments, the target margin of exposure (MOE) was 300, which incorporates the FQPA Safety Factor of 3x. MOEs calculated for residential handler's inhalation exposure and children's oral exposures were well above the target of 300; and therefore, do not exceed the Agency's level of concern.

4. *Cumulative exposure to substances with a common mechanism of toxicity*. Section 408(b)(2)(D)(v) requires that, when considering whether to establish, modify, or revoke a tolerance, 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 does not have, at this time, available data to determine whether clopyralid has a common mechanism of toxicity with other substances or how to include this pesticide in a cumulative risk assessment. Unlike other pesticides for which EPA has followed a cumulative risk approach based on a common mechanism of toxicity, clopyralid does not appear to produce a toxic metabolite produced by other substances. For the purposes of this tolerance action, therefore, EPA has not assumed that clopyralid has a common mechanism of toxicity with other substances. For information regarding EPA's efforts to determine which chemicals have a common mechanism of toxicity and to evaluate the cumulative effects of such chemicals, see the final rule for Bifenthrin Pesticide Tolerances (62 FR 62961, November 26, 1997).

D. Safety Factor for Infants and Children

1. *In general*. FFDCA section 408 provides that EPA shall apply an additional tenfold margin of safety for infants and children in the case of threshold effects to account for prenatal and postnatal toxicity and the completeness of the data base on toxicity and exposure unless EPA determines that a different margin of safety will be safe for infants and children. Margins of safety are incorporated into EPA risk assessments either directly through use of a margin of exposure (MOE) analysis or through using uncertainty (safety) factors in calculating a dose level that poses no appreciable risk to humans.

2. *Prenatal and postnatal sensitivity*. No increased quantitative or qualitative susceptibility was seen following pre- and/or post-natal exposures. In rabbit and rat developmental toxicity studies, the effects seen in fetuses are at dose levels equal to or greater than doses where maternal toxicity is seen. In a 2-generation reproductive toxicity study in rats, the effects seen in offspring were at dose levels equal to or greater than doses where parental toxicity is seen.

3. *Conclusion*. EPA determined that an additional factor to protect infants and children was appropriate because of a data gap for a developmental neurotoxicity study in rats. This study was required due to the concern for malformations (hydrocephalus) seen in the prenatal developmental toxicity study in rabbits; EPA decided on an additional factor of 3 rather than the statutory default factor of 10 because the existing toxicology database, which is complete except for the newly required developmental neurotoxicity study, revealed no quantitative or qualitative evidence of increased susceptibility following *in utero* exposure to rats and rabbits and/or following prenatal/ postnatal exposure to rats; and dietary (food and drinking water) and residential exposure assessments will not underestimate the potential exposures for infants, children, and/or women of childbearing age from the use of clopyralid.

E. Aggregate Risks and Determination of Safety

To estimate total aggregate exposure to a pesticide from food, drinking water, and residential uses, the Agency calculates DWLOCs which are used as a point of comparison against the model estimates of a pesticide's concentration in water (EECs). DWLOC values are not regulatory standards for drinking water. DWLOCs are theoretical upper limits on

a pesticide's concentration in drinking water in light of total aggregate exposure to a pesticide in food and residential uses. In calculating a DWLOC, the Agency determines how much of the acceptable exposure (i.e., the PAD) is available for exposure through drinking water e.g., allowable chronic water exposure (mg/kg/day) = cPAD - (average food + residential exposure). This allowable exposure through drinking water is used to calculate a DWLOC.

A DWLOC will vary depending on the toxic endpoint, drinking water consumption, and body weights. Default body weights and consumption values as used by the USEPA Office of Water are used to calculate DWLOCs: 2L/70 kg (adult male), 2L/60 kg (adult female), and 1L/10 kg (child). Default body weights and drinking water consumption values vary on an individual basis. This variation will be taken into account in more refined screening-level and quantitative drinking water exposure assessments. Different populations will have different DWLOCs. Generally, a DWLOC is calculated for each type of risk assessment used: acute, short-term, intermediate-term, chronic, and cancer.

When EECs for surface water and groundwater are less than the calculated DWLOCs, OPP concludes with reasonable certainty that exposures to the pesticide in drinking water (when considered along with other sources of exposure for which OPP has reliable data) would not result in unacceptable levels of aggregate human health risk at this time. Because OPP considers the aggregate risk resulting from multiple exposure pathways associated with a pesticide's uses, levels of comparison in drinking water may vary as those uses change. If new uses are added in the future, OPP will reassess the potential impacts of residues of the pesticide in drinking water as a part of the aggregate risk assessment process.

1. *Acute risk.* Using the exposure assumptions discussed in this unit for acute exposure, the acute dietary exposure from food to clopyralid will occupy 8% of the aPAD for the U.S. population, 5% of the aPAD for females 13–50 years, 9% of the aPAD for all infants <1 year and 13% of the aPAD for children between 1 and 6 years old. In addition, there is potential for acute dietary exposure to clopyralid in drinking water. After calculating DWLOCs and comparing them to the EECs for surface and ground water, EPA does not expect the aggregate exposure to exceed 100% of the aPAD, as shown in the following Table 3:

TABLE 3.—AGGREGATE RISK ASSESSMENT FOR ACUTE EXPOSURE TO CLOPYRALID

Population Subgroup	aPAD (mg/kg)	%aPAD (Food)	Surface Water EEC (ppb)	Ground Water EEC (ppb)	Acute DWLOC (ppb)
U.S. Population	0.25	8	9	9.7	8,100
All infants (< 1 year)	0.25	9	9	9.7	2,300
Children 1–6 years	0.25	13	9	9.7	2,200
Females 13–50 years	0.25	5	9	9.7	7,200

2. *Chronic risk.* Using the exposure assumptions described in this unit for chronic exposure, EPA has concluded that exposure to clopyralid from food will utilize 14% of the cPAD for the U.S. population, 11% of the cPAD for all infants < 1 year and 34% of the cPAD for children between 1 and 6 years old. Based on the use pattern, chronic residential exposure to residues of clopyralid is not expected. In addition, there is potential for chronic dietary exposure to clopyralid in drinking water. After calculating DWLOCs and comparing them to the EECs for surface and ground water, EPA does not expect the aggregate exposure to exceed 100% of the cPAD, as shown in the following Table 4:

TABLE 4.—AGGREGATE RISK ASSESSMENT FOR CHRONIC (NON-CANCER) EXPOSURE TO CLOPYRALID

Population Subgroup	cPAD mg/kg/day	% cPAD (Food)	Surface Water EEC (ppb)	Ground Water EEC (ppb)	Chronic DWLOC (ppb)
U.S. Population	0.05	14	9	9.7	1,500
All infants (< 1 year)	0.05	11	9	9.7	450
Children 1–6 years	0.05	34	9	9.7	330
Females 13–50 years	0.05	11	9	9.7	1,300

3. *Short-term risk.* Short-term aggregate exposure takes into account residential exposure plus chronic exposure to food and water (considered to be a background exposure level).

Clopyralid is currently registered for use that could result in short-term residential exposure and the Agency has determined that it is appropriate to aggregate chronic food and water and short-term exposures for clopyralid.

Using the exposure assumptions described in this unit for short-term exposures, EPA has concluded that food and residential exposures aggregated result in aggregate MOEs of 10,000 (U.S. population, food and residential), 14,000 (females 13–50, food and residential) and 3,100 (children 1–6 years old, food and residential). These aggregate MOEs do not exceed the Agency's level of concern for aggregate exposure to food and residential uses. In addition, short-term DWLOCs were calculated and compared to the EECs for chronic exposure of clopyralid in ground and surface water. After calculating DWLOCs and comparing them to the EECs for surface and ground water, EPA does not expect short-term aggregate exposure to exceed the Agency's level of concern, as shown in the following Table 5:

TABLE 5.—AGGREGATE RISK ASSESSMENT FOR SHORT-TERM EXPOSURE TO CLOPYRALID

Population Subgroup	Aggregate MOE (Food + Residential)	Aggregate Level of Concern (LOC)	Surface Water EEC (ppb)	Ground Water EEC (ppb)	Short-Term DWLOC (ppb)
U.S. Population	10,000	300	9	9.7	8,500
Females 13–50	14,000	300	9	9.7	7,300
Children 1–6 years	3,100	300	9	9.7	2,300

4. *Intermediate-term risk*. Intermediate-term aggregate exposure takes into account residential exposure plus chronic exposure to food and water (considered to be a background exposure level).

Clopyralid is currently registered for use(s) that could result in intermediate-term residential exposure and the Agency has determined that it is appropriate to aggregate chronic food and water and intermediate-term exposures for clopyralid.

Using the exposure assumptions described in this unit for intermediate-term exposures, EPA has concluded that food and residential exposures aggregated result in aggregate MOEs of 10,000 (U.S. Population, food only), 14,000 (females 13–50, food only) and 3,800 (children 1–6 years, food and residential). These aggregate MOEs do not exceed the Agency's level of concern for aggregate exposure to food and residential uses. In addition, intermediate-term DWLOCs were calculated and compared to the EECs for chronic exposure of clopyralid in ground and surface water. After calculating DWLOCs and comparing them to the EECs for surface and ground water, EPA does not expect intermediate-term aggregate exposure to exceed the Agency's level of concern, as shown in the following Table 6:

TABLE 6.—AGGREGATE AGGREGATE RISK ASSESSMENT FOR INTERMEDIATE-TERM EXPOSURE TO CLOPYRALID

Population Subgroup	Aggregate MOE (Food + Residential)	Aggregate Level of Concern (LOC)	Surface Water EEC (ppb)	Ground Water EEC (ppb)	Inter-mediate-Term DWLOC (ppb)
U.S. Population	10,000	300	9	9.7	8,500
Females 13–50	14,000	300	9	9.7	7,300
Children 1–6 years	3,800	300	9	9.7	2,300

5. *Aggregate cancer risk for U.S. population*. The Agency concluded that clopyralid was negative for carcinogenicity potential in rats and mice and classified clopyralid as ''not likely'' to be a human carcinogen according to EPA Draft Guidelines for Carcinogen Risk Assessment. Therefore, a cancer risk assessment was not performed.

6. *Determination of safety*. Based on these risk assessments, EPA concludes that there is a reasonable certainty that no harm will result to the general population, and to infants and children from aggregate exposure to clopyralid residues.

IV. Other Considerations

A. Analytical Enforcement Methodology

An adequate residue analytical method is available for enforcement of the proposed tolerances. This method, ACR 75.6, determines clopyralid as the methyl ester by gas chromatography using electron capture detection. This method has been successfully validated by the Biological and Economic Analysis Division's (BEAD) Analytical Chemistry Branch and has been published in FDA's Pesticide Analytical Manual, Vol-II (PAM II).

An adequate residue analytical method is also available for the enforcement of the proposed tolerance on animal commodities. This method, ACR 86.1, determines clopyralid as the methyl ester by gas chromatography using electron capture detection. This method has been successfully validated by BEAD's Analytical Chemistry Branch and has been published in FDA's Pesticide Analytical Manual, Vol-II (PAM II).

B. International Residue Limits

There are no Codex or Mexican maximum residue limits (MRLs). Canada has set a maximum residue limit of 2.0 ppm for barley, oats, and wheat, and 7.0 ppm for the milled fractions of barley, oats, and wheat (excluding flour).

C. Conditions

A revised label is needed to specify (1) a 48–hour restricted entry interval, and (2) whether plantback intervals for crops not listed in the crop rotation table will be 10.5 months or whether rotation to crops not listed will be prohibited. As a condition of registration, the registrant also needs to submit a developmental neurotoxicity study (870.6300) because neuropathology or central nervous system malformations were seen in the rabbit developmental toxicity study.

V. Conclusion

Therefore, tolerances are amended for residues of clopyralid (3,6-dichloro-2-pyridinecarboxylic acid), in or on sugar beet roots at 2.0 ppm and sugar beet tops at 3.0. In addition, a tolerance is established for residues of clopyralid in or on sugar beet molasses at 10 ppm. Finally, the established tolerances for barley forage at 9 ppm and milled fractions (except flour) of barley, oats and wheat at 12 ppm are being added back to the tolerance expression for clopyralid after being inadvertently deleted.

VI. 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–301099 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 March 12, 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 VI.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–301099, 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 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).

VII. Regulatory Assessment Requirements

This final rule establishes a tolerance 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*(58 FR 51735, October 4, 1993). 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* (63 FR 27655, May 19, 1998); special considerations as required by Executive Order 12898, entitled *Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations* (59 FR 7629, February 16, 1994); or require OMB review or any Agency action under Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* (62 FR 19885, April 23, 1997). 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 tolerance 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* (64 FR 43255, August 10, 1999). 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).

VIII. 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: December 26, 2000.

James Jones,

Director, Registration Division, Office of Pesticide Programs.

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 371.

2. Section 180.431 is amended by removing the entries for ''sugar beet roots'' and ''sugar beet tops'' and alphabetically adding commodities to the table in paragraph (a) to read as follows:

§ 180.431 Clopyralid; tolerances for residues.

(a) * * *

Commodity	Parts per million
* * * * *	
Barley, forage	9.0
* * * * *	
Barley, milled fractions (except flour)	12
* * * * *	
Beet, sugar, molasses	10
Beet, sugar, roots	2.0
Beet, sugar, tops	3.0
* * * * *	
Oats, milled fractions (except flour)	12
* * * * *	
Wheat, milled fractions (except flour)	12

* * * * *

[FR Doc. 01–745 Filed 1–10–01; 8:45 am]

BILLING CODE 6560–50–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 435

[HCFA–2086–F]

RIN 0938–AJ96

Medicaid Program; Change in Application of Federal Financial Participation Limits

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

ACTION: Final rule.

SUMMARY: This final rule changes the current requirement that limits on Federal Financial Participation (FFP) must be applied before States use less restrictive income methodologies than those used by related cash assistance programs in determining eligibility for Medicaid. This change was originally published as a proposed rule on October 31, 2000 (65 FR 64919).

This regulatory change is necessary because the current regulatory interpretation of how the FFP limits apply to income methodologies under section 1902(r)(2) of the Social Security Act (the Act) unnecessarily restricts States' ability to take advantage of the authority to use less restrictive income methodologies under that section of the statute. While the enactment of section 1902(r)(2) of the Act could be read in the limited manner embodied in current regulations the statute does not require such a reading, and subsequent State experience with implementing section 1902(r)(2)of the Act calls into question the current regulation's approach.

EFFECTIVE DATE: These regulations are effective on March 12, 2001.

FOR FURTHER INFORMATION CONTACT: Roy Trudel, (410) 786–3417.

SUPPLEMENTARY INFORMATION: Generally, in determining financial eligibility of individuals for the Medicaid program, State agencies must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's status. Our regulations at 42 CFR 435.601 set forth the requirements for State agencies applying less restrictive income and resource methodologies when determining Medicaid eligibility under the authority of section 1902(r)(2) of the Social Security Act (the Act). Current regulations at 42 CFR 435.1007 provide that when States use less restrictive income and resource methodologies under section 1902(r)(2), the limits on Federal Financial Participation (FFP) in section 1903(f) of the Act apply before application of any less restrictive income methodologies. We are amending that regulation to change this requirement so that the 133⅓ percent FFP limit contained in section 1903(f)(1) of the Social Security Act would apply after application of any less restrictive income methodologies under section 1902(r)(2) of the Act.

The adoption of this policy gives States additional flexibility in setting Medicaid eligibility requirements. Also, we believe adoption of this policy reflects the intent of Congress to move the Medicaid program away from cash assistance program rules, as evidenced by enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which severed the link between the Aid to Families with Dependent Children (AFDC) program and Medicaid.

I. Background

Section 2373(c) of the Deficit Reduction Act of 1984 (DRA) established a moratorium period beginning on October 1, 1981, during which the Secretary was prohibited from taking any compliance, disallowance, penalty, or other regulatory action against a State because a State's Medicaid plan included a standard or methodology for determining financial eligibility for the medically needy that the Secretary determined was less restrictive than the

standard or methodology required under the related cash assistance program.

The provisions of the DRA moratorium were clarified by section 9 of the Medicare and Medicaid Patient Program Protection Act of 1987. Section 9 amended section 2373(c) of DRA to specify that the moratorium applied to the Secretary's compliance, disallowance, penalty, or other regulatory actions against a State because the State plan is determined to be in violation of provisions of the Act for coverage, as optional categorically needy, of certain aged, blind, and disabled individuals who were in institutions or receiving home and community-based services, as well as methodologies for determining financial eligibility of the medically needy.

The moratorium applied to an amendment or other changes in Medicaid State plans, or operation or program manuals, regardless of whether the Secretary had approved, disapproved, acted upon, or not acted upon the amendment or other change, or operation or program manual.

Authority to adopt less restrictive financial methodologies as part of a State's Medicaid plan was added to the law in 1988. Section 303(e) of the Medicare Catastrophic Coverage Act of 1988, enacted on July 1, 1988 (and amended by section 608(d)(16)(C) of the Family Support Act of 1988), amended the Act to permit States to use less restrictive financial methodologies in determining eligibility not only for the medically needy eligibility group at section 1902(a)(10)(C) of the Act, but also for specified categorically needy groups of individuals. These categorically needy groups include qualified pregnant women and children (section 1902(a)(10)(A)(i)(III) of the Act), poverty level pregnant women and infants (section 1902(a)(10)(A)(i)(IV) of the Act), qualified Medicare beneficiaries (section 1905(p) of the Act), all of the optional categorically needy groups specified in section 1902(a)(10)(A)(ii) of the Act, and individuals in States that have elected, under section 1902(f) of the Act, to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. This provision of the Medicare Catastrophic Coverage Act was effective for medical assistance furnished on or after October 1, 1982. This authority was codified in a new section 1902(r)(2) of the Act.

The application of FFP limits prior to the use of more liberal income methodologies under section 1902(r)(2) of the Act was based on the Senate Report accompanying the 1987 amendment to the DRA moratorium (Senate Report No. 109, 100th Congress, 1st session at 24–25) which stated that:

> The moratorium does not eliminate the limits on income and resources of eligible individuals and families under section 1903(f) (including the requirements that the applicable medically needy income level not exceed the amount determined in accordance with standards prescribed by the Secretary to be equivalent to 133⅓ percent of the most generous AFDC eligibility standard, and that the income of individuals receiving a State supplementary payment in a medical institution or receiving home and community-based services under a special income standard not exceed 300% of the SSI standard). The moratorium also does not permit States to provide Medicaid benefits to those who are not ''categorically related'' individuals (that is, individuals who would not be eligible for Medicaid, regardless of the amount of their income and resources)''.

Since, as the legislative history indicates, section 1902(r)(2) of the Act is essentially the codification of the DRA moratorium, we continued to apply the 133⅓ percent FFP limit at section 1903(f)(1) of the Act when developing the implementing regulations for section 1902(r)(2) of the Act.

However, subsequent experience has shown that the policy we adopted restricted the flexibility Congress intended States to have when it enacted section 1902(r)(2) of the Act in ways we did not foresee when we published the current regulations. The real effect of the policy we adopted was to make it almost impossible for States to actually use less restrictive income methodologies for many eligibility groups, including the medically needy, because use of such methodologies would violate the 133⅓ percent FFP limit. States have noted that the application of the 133⅓ percent FFP limit prior to use of less restrictive income methodologies unnecessarily limits their flexibility to provide health coverage under Medicaid and to simplify program administration by modifying cash assistance financial methodologies that do not work well in the Medicaid context.

Further, the passage of Pub. L. 104–193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, leads us to believe that the current application of the FFP income limits under section 1902(r)(2) of the Act no longer reflects Congressional intent. In enacting this legislation, Congress clearly expressed its intent that States should have the flexibility to depart from cash assistance program-based income criteria to define Medicaid eligibility. Given that Congress chose to sever the link between cash assistance and Medicaid under this legislation, we believe it is valid to conclude that Congress did not actually intend that FFP limits, which are based on cash assistance standards, apply prior to use of less restrictive financial methodologies under section 1902(r)(2) of the Act for those eligibility groups to which section 1902(r)(2) of the Act applies.

Also, section 1903(f) of the Act was enacted prior to section 1902(r)(2) of the Act. Had Congress intended that the 133⅓ percent FFP limit apply prior to use of less restrictive income methodologies, it could have amended section 1903(f)(1) of the Act or section 1902(r)(2) of the Act to so state. The fact that section 1903(f)(1) of the Act was not so amended indicates that Congress intended that the 133⅓ percent FFP limit apply after, not before, use of less restrictive income methodologies.

Thus, the change in this regulation gives States needed additional flexibility in setting Medicaid eligibility requirements. Even though section 1902(r)(2) of the Act was derived from the DRA moratorium, its own legislative history did not contain any similar discussion of its interaction with the section 1903(f) of the Act FFP limits. As such, we do not believe it is necessary to consider the legislative history of DRA to be determinative of Congressional understanding of the operation of section 1902(r)(2) of the Act.

II. Provisions of the Final Regulations

We are amending § 435.1007 to change the requirement that the 133 ⅓ percent FFP limit applies prior to use of any less restrictive income methodologies under section 1902(r)(2) of the Act.

Section 435.1007 Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries

In § 435.1007(b), we are deleting the phrase ''does not exceed'' and replace it with the word ''exceeds''. This is purely an editorial and technical change to correct an error in wording in the current regulation which is contrary to statute. This change is necessary in order to conform the regulation to the statute's requirement. This change was explained in the proposed rule. We received no public comments on this change.

In § 435.1007, we are amending paragraph (e) by removing the phrase ''are applied and before the less restrictive income deductions under § 435.601(c)'' and replacing it with the following language: ''and any income disregards in the State plan authorized under section 1902(r)(2)''.

We are further amending § 435.1007 by adding a new paragraph (f) to read: ''A State may use the less restrictive income methodologies included under its State plan as authorized under § 435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.''

III. Analysis of and Responses to Public Comments

We received a total of 37 comments from States, advocacy groups, associations and a few individuals on the proposed regulation that was published on October 31, 2000 (65 FR 64919). All of the comments we received expressed support for the proposed change. A number chose not to offer any suggestions or other comments beyond an expression of support. Some offered examples, similar to those we included in the preamble to the NPRM, of ways States could use the proposed change to alleviate current problems with their Medicaid programs. These included such things as raising low medically needy income levels, reducing institutional bias, and administrative simplification. We appreciate the overwhelming show of support for the proposed change.

In addition to expressing support for the proposed rule, a number of commenters offered comments on five separate issues concerning the proposed change. Those comments, and our responses, are discussed below.

Comment: One commenter expressed concern that unless changes are also made to a number of subsections of 42 CFR 435, HCFA will not be bound by the proposed policy change. The commenter expressed further concern that unless additional changes are made, States might still be subject to FFP penalties if an individual's income prior to application of the less restrictive methodologies adopted pursuant to section 1902(r)(2) of the Act exceeds the FFP limitation in section 1903(f) of the Act.

Response: We do not agree that additional changes to the regulations are needed. We believe that the proposed change makes it clear that income remaining after application of any less restrictive methodologies adopted pursuant to section 1902(r)(2) of the Act is the income used to determine whether the 133⅓ percent limitation on FFP is exceeded under all circumstances. States will not be subject to FFP penalties because income prior to application of the less restrictive methodologies exceeds the 133⅓ percent limitation in section 1903(f)(1) of the Act. We proposed this change with the express intent that States would not be subject to such FFP penalties, and we believe that the changes adopted here accomplish that goal. We are clearly bound by this regulation as we are bound by all regulations that we promulgate.

Comment: Several commenters urged that the proposed change go into effect as soon as possible; some requested an effective date of January 1, 2001.

Response: We agree that the change should be effective at the earliest possible date. However, this regulation is considered to be a major rule and the statute governing congressional review of agency rulemaking requires that final regulations that are major rules cannot be effective sooner than 60 days after publication in the **Federal Register** unless a showing of good cause to dispense with the notice and public comment procedures that were included in the rule. To make this showing the agency must find that notice and public comment procedures are impracticable, unnecessary, or contrary to the public interest. We do not believe we can satisfy this test since the rule is being adopted after notice and public comment. The effective date of this change is set forth in the Effective Date section of this final rule.

Comment: Several commenters suggested that the preamble be expanded to include such things as a clear explanation and list of the eligibility groups to which the proposed change would apply, a similar list of the groups to which section 1902(r)(2) of the Act applies but which were not subject to the FFP limits under the old regulation, and discussions of steps States can take to make their income eligibility policies more supportive of efforts to integrate people with disabilities in the mainstream of community life. One commenter also suggested providing ongoing guidance on this general subject in a publicly visible place such as the HCFA website.

Response: In general, the new rule applies to all of the optional categorically needy eligibility groups cited in the statute at section 1902(a)(10)(A)(ii) of the Act *except* for those groups which were already exempt from the FFP limits under existing statute (section 1903(f)(4) of the Act). Also, the new rule applies to the medically needy.

We agree that more information about the various topics listed above would be of considerable value to States and other interested parties. However, this final rule is not a technical assistance document, and for that reason we believe that much of the detailed programmatic information and advice suggested by the commenters is best provided through other venues. Rather than include this kind of extensive material regarding more general Medicaid eligibility topics in the preamble to this final rule, we will provide guidance on these and similar issues to States and others through an administrative issuance, such as a letter to all State Medicaid Directors. Administrative guidance issued in such a form would also be available to the public on HCFA's website.

Comment: One commenter suggested that in addition to our proposed revision of the regulations at § 435.1007, we should similarly revise the regulations at § 435.1005 to allow the use of less restrictive income methodologies before applying the FFP limits for the special income level group (section 1902(a)(10)(A)(ii)(V) of the Act). This would enable States to disregard additional income for individuals eligible under this group.

Response: We understand the commenter's interest in not having the FFP limits apply to less restrictive income disregards for the special income level group. However, the Medicaid statute precludes our doing so.

Most of the eligibility groups to which the FFP limits apply are subject to a limit that is defined in section 1903(f)(1)(B)(i) of the Act as 133⅓ percent of the State's AFDC payment standard. The special income level group, however, is subject to a different FFP limit which is defined in section 1903(f)(4)(C) of the Act as 300 percent of the SSI Federal Benefit Rate. Further, this section of the statute includes specific requirements for how a person's income is to be counted in determining whether his or her income exceeds the 300 percent FFP limit. Under the statute, the person's income is determined under section 1612 of the Act, but without regard to the exclusions and disregards listed in subsection 1612(b) of the Act.

In other words, the person's gross income, without the application of any disregards normally used by the SSI program to determine eligibility, must be used to determine whether the person's income exceeds the 300 percent FFP limit. By contrast, the sections of the statute pertaining to the 133⅓ percent FFP limit do not include similar specific requirements for how income is to be counted in determining whether a person's income exceeds the FFP limit.

Because section 1903(f)(4)(C) of the Act specifies how income is to be counted in determining whether a person's income exceeds the 300

percent FFP limit, the statute precludes our being able to permit, via regulation, the use of less restrictive income methodologies prior to application of that FFP limit. The statute itself would have to be changed to permit the use of less restrictive income methodologies in that manner.

Comment: Three commenters suggested that we make the use of less restrictive methodologies mandatory for States rather than their use being optional as is now the case. One commenter further suggested that provision of home and community-based waiver services should also be made mandatory for States.

Response: Use of less restrictive methodologies and provision of home and community-based waiver services is optional for States because the Medicaid statute gives States the choice of using such methodologies and providing such services. Given the language of the statute itself, we have no authority to require through regulations that States use less restrictive methodologies or provide home and community-based waiver services.

IV. Provisions of the Final Regulations

This final rule incorporates in their entirety the provisions of the proposed rule.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

VI. Regulatory Impact

A. Overall Impact

We and the Office of Management and Budget have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review) and the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354). 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 in any one year). This rule is considered to be a major rule with economically significant effects.

The cost impact of this final rule is extremely difficult to project, given the broad discretion and flexibility that States will have in implementing its provisions. In the proposed rule we cited a projected cost to the Federal government of $860 million over 5 years for Medicaid and $100 million for Medicare. As those estimates were based on information from only two States, we solicited feedback on the potential financial impact this rule might have. We received no comments specifically related to cost issues in the responses to the proposed rule; nevertheless, we are providing additional detail concerning the original cost estimates. The table below summarizes our estimated 5-year costs to Medicaid and Medicare.

ESTIMATED COST OF REMOVING FFP LIMITS UNDER SECTION 1902(r)(2) OF THE ACT

(Costs in millions of dollars)

	FFY 2001	FFY 2002	FFY 2003	FFY 2004	FFY 2005	FFYs 2001–2005
Federal Medicaid	40	125	220	230	245	860
State Medicaid	30	100	175	185	190	680
Total Medicaid	70	225	395	415	435	1540
Medicare	10	15	25	25	25	100

As stated in the proposed rule, these estimates were developed from cost information about two States (Utah and California) which expressed interest in using the regulation to expand their Medicaid programs. Estimated costs for these States were related to their aggregate Medicaid spending for the medically needy and projected to the national level assuming that states representing one-fourth of Medicaid expenditures would implement changes of a similar magnitude. The one-fourth assumption was based on our belief that the potential costs of broader expansions would serve to limit State participation, at least during the 5-year budget window. The Medicare cost results from increased payments under the Medicare disproportionate share hospital (DSH) program and results from the anticipated increase in Medicaid enrollment accompanying the Medicaid costs shown above. Projected Medicare DSH cost per Medicaid beneficiary were applied to this increased enrollment to obtain the $100 million 5-year Medicare DSH cost.

Arriving at the Medicaid and Medicare costs was difficult due to the fact that implementation of the option under this rule is entirely at the discretion of the State. Further, States that choose to exercise the option have great latitude in establishing the extent to which, and the eligibility groups for which, the option would be applied under their State Medicaid plans.

Benefits of the Proposed Rule Change

We believe this change will benefit both States and individuals in a number of ways. For example, under normal eligibility rules, States are required to count many kinds of income. Some of these types of income are administratively burdensome to deal with, and often do not materially affect the outcome of the eligibility determination. Some examples are the value of food or shelter provided to an applicant (called in-kind support and maintenance), income belonging to a parent of a child, or a spouse who is not applying for benefits (called deemed income), and low amounts of income such as interest earned on savings accounts. This final rule will allow States to use income disregards to simplify the process of determining eligibility by not counting types of income that primarily impose an administrative burden.

Medically Needy Income Limits

Under a medically needy program, States can choose to cover under Medicaid individuals with income that is too high to otherwise be eligible, but who, by subtracting incurred medical expenses from their income, could reduce their income to the State's medically needy income standard. This process is known as spending down excess income, or ''spenddown''.

However, in many States the medically needy income standard is very low; in at least 22 States, the

medically needy income standard is actually lower than the income standard for SSI benefits ($512 a month for an individual in 2000). In four States, the medically needy income standard is less than $200 a month. This creates a situation where individuals whose income is just slightly over the limit that would allow them to receive Medicaid as SSI recipients must spend down a certain amount of ''excess'' income to reach the medically needy income level.

For example, a person with $512 a month in countable income can be eligible for SSI and receive Medicaid coverage in most States. A person with just $1 more cannot be eligible for SSI, and thus cannot receive Medicaid health coverage based on receiving SSI benefits. Depending on a particular State's medically needy income level, such an individual with $513 in countable monthly income may have to spend over $300 on medical care each month just to reach a medically needy income limit that is that far below the SSI level.

Under the Medicaid statute, States cannot just increase their medically needy income levels to deal with this problem. However, under this final rule, a State could use section 1902(r)(2) of the Act to disregard additional amounts of income under its medically needy program, effectively reducing or even eliminating the large spenddown liability described in the example above.

Helping People Move from Institutions to the Community

The medically needy spenddown problem described above can also have adverse effects for people in medical institutions who would like to receive care in community settings. Since Medicaid will pay for room and board expenses in a medical institution, the individual needs to retain relatively little income after application of the medically needy spenddown requirement. However, Medicaid will not pay for room or board expenses in a community setting. Few individuals will be able to move from a medical institution to the community if they are permitted to retain only $200–$400 after meeting Medicaid spenddown requirements.

The practical effect of this is that many people in institutions who would like to move to the community, and who would normally be able to manage in a community setting, remain in the institution because they literally cannot leave. This final rule gives States opportunities to correct spenddown problems so that more people could leave institutional settings and live in the community.

Encouraging Work Effort

While legislation enacted in the last few years has given States new options for providing Medicaid to individuals with disabilities who want to work, States may want to encourage work effort among individuals eligible under other groups such as the medically needy, or among individuals who may not readily fit into one of the new work incentives groups. One way to encourage work effort is to allow people to keep more of the income they earn without forcing them to either spend more for medical care under a medically needy spenddown, or risk losing Medicaid altogether.

Under section 1902(r)(2) of the Act a State could do that by increasing the amount of earned income that is not counted in determining a person's eligibility. However, the current application of the FFP limits to the use of less restrictive income disregards effectively precludes States from offering that kind of encouragement for many eligibility groups. This final rule removes that restriction, giving States another way to encourage work effort.

Expanding Health Coverage

In addition to the specific examples described above, section 1902(r)(2) of the Act gives States the option of extending health coverage to more individuals by disregarding additional types and amounts of income, thereby allowing people who could not otherwise meet the program's eligibility requirements to become eligible. However, the current application of the FFP limits to the use of less restrictive income disregards greatly reduces the options States have to implement that kind of health coverage expansion. This final rule will give States the full flexibility provided by section 1902(r)(2) of the Act to expand their base of eligible individuals if they choose to do so.

Youth Age 19–20 Years

This change provides State flexibility to offer health coverage to youth 19 and 20 years of age consistent with the health coverage options available under Federal law to children under 19 years of age as described in section 1902(l) of the Act. Such youth are often at a high risk of being uninsured because they are still in school or beginning employment. To clarify, youth 19 and 20 years of age are included in the group described in section 1902(a)(10)(A)(ii)(I) of the Act. Under current statutory and regulatory authority, States are able to effectively expand eligibility of all children under 19 years of age to whatever level they choose. However, the eligibility of youth 19 to 20 years of age (as children) is limited to the group noted above, and that group is currently subject to the FFP cap. This final regulation allows States to expand eligibility for these older children to the same level that they use for children under 19 years of age.

Effect on Small Businesses and Small Rural Hospitals

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and government 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. Individuals and States are not included in the definition of a small entity.

We expect that small entities will be indirectly impacted by this final rule. We expect that any indirect impact will be positive. States will decide individually whether to take advantage of the options that this final rule makes available. If a State exercises the options under this final rule, small entities such as small businesses, nonprofit organizations, and governmental agencies may receive additional Medicaid payments as a result of their service to the increased number of individuals who would be eligible under the program. We invited comments in this area and received none. Because the indirect impact on small entities depends on the extent and degree to which States exercise the options under this rule and the number of small entities that may be indirectly impacted, we are unable with any degree of certainty to estimate the fiscal impact on small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

This final rule will have only indirect impact on small rural hospitals. We believe that any indirect impact will be positive. This final rule primarily affects States and each State will make its own decision regarding acceptance of the options presented in these regulations. As a result, small rural hospitals are in no way involved in the decision-making

process and would be impacted only to the extent that a State's use of less restrictive income methodologies could result in some increase in the number of individuals eligible for Medicaid. This in turn could result in a slight increase in utilization of rural hospital services which could increase the Medicaid payment received by these hospitals. We invited comments in this area and received none. Because the indirect impact on small rural hospitals depends on the extent and degree to which States exercise the options under this rule and the number of small rural hospitals that may be indirectly impacted, we are unable with any degree of certainty to estimate the fiscal impact on small rural hospitals.

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 by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in any one year. This final rule will have no impact on the private sector. The rule imposes no requirements on State, local or tribal governments. Rather, it offers State governments additional flexibility in operating their Medicaid programs, but does not require that they make any changes in their programs.

Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that would impose substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule imposes no requirement costs on governments, nor does it preempt State law or otherwise have Federalism implications.

We have had discussions of this issue with a number of State governments since approximately 1990. Those discussions have taken place both with individual States and with groups of States, including HCFA's Medicaid Eligibility Technical Advisory Group and the National Association of State Medicaid Directors Executive Committee. Based on the many discussions we have had, and comments we received as discussed elsewhere in this final rule, we believe States are overwhelmingly in favor of the change.

B. Anticipated Effects

1. Effects on State Governments

This final rule gives States greater flexibility in designing and operating their Medicaid programs.

2. Effects on Providers

Providers will only be indirectly affected by this rule and we expect any indirect impact will be positive. Each State will decide whether to take advantage of the options the regulations make available. To the extent that States decide to exercise their options under this final rule, we expect the ultimate indirect impact on providers to be positive due to the added Medicaid revenues that providers may garner.

3. Effects on the Medicare and Medicaid Programs

This rule may increase Medicare costs by about $100 million over 5 years. Since the rule may increase the number of individuals eligible for Medicaid who receive inpatient hospital services, it may affect the calculation of hospitals' disproportionate share hospital (DSH) calculations under the Medicare program. We estimate that Medicare DSH payments could increase by $100 million over 5 years due to changes in this rule.

Under Medicaid, it is projected that the Federal cost of this rule could be as much as $860 million over 5 years. However, because actual implementation of the provisions of the rule is strictly at the option of each State, actual Federal program costs would depend on whether, and to what degree, States choose to take advantage of the flexibility provided by this final rule.

C. Alternatives Considered

There were few alternatives to the proposed rule to consider. One alternative was to maintain the requirement that the FFP limits apply prior to use of less restrictive income methodologies under § 435.601, but allow additional disregards at a somewhat higher level than is possible under the current regulations. However, this would not provide States the level of flexibility to operate their Medicaid programs that is provided under the proposed rule, and thus would be of only limited value. We rejected this alternative because it would not give States what they need to effectively operate their Medicaid programs.

We also considered pursuing a legislative option that would have changed the Medicaid statute itself to clarify that the FFP limits at section 1903(f) of the Act should apply after, rather than before, the use of any less restrictive income methodologies under section 1902(r)(2) of the Act. However, as explained previously the current policy concerning application of the FFP limits to less restrictive income methodologies does not reflect a clear statutory requirement, but rather is an administrative interpretation of the statute. Since the statute as written will support this change in policy, we believed the issue should be addressed via a change in the regulations rather than a change in the statute. Also, we believe that this rule is the most efficient and expedient way of accomplishing the desired change.

D. Conclusion

We expect this rule to benefit State Medicaid programs and Medicaid beneficiaries by giving States additional flexibility in designing and operating their programs. In turn, this would allow States to make individuals eligible for Medicaid who otherwise could not be eligible under the current regulations.

Because this rule is considered major rule that is economically significant, we have prepared a regulatory impact statement. We believe that this rule will have an estimated cost of $960 million dollars over 5 years based on best available data. In addition, we certify that this rule will not 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.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

For the reasons set forth in the preamble, 42 CFR part 435 is amended as set forth below:

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

1. The authority citation for part 435 continues to read as follows:

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

2. Section 435.1007 is amended by revising paragraphs (b) and (e) and adding paragraph (f) to read as follows:

§ 435.1007 Categorically needy, medically needy, and qualified Medicare beneficiaries.

* * * * *

(b) Except as provided in paragraphs (c) and (d) of this section, FFP is not available in State expenditures for individuals (including the medically needy) whose annual income after deductions specified in § 435.831(a) and (c) exceeds the following amounts, rounded to the next higher multiple of $100.

* * * * *

(e) FFP is not available in expenditures for services provided to categorically needy and medically needy recipients subject to the FFP limits if their annual income, after the cash assistance income deductions and any income disregards in the State plan authorized under section 1902(r)(2) of the Act are applied, exceeds the 133⅓ percent limitation described under paragraphs (b), (c), and (d) of this section.

(f) A State may use the less restrictive income methodologies included under its State plan as authorized under § 435.601 in determining whether a family's income exceeds the limitation described in paragraph (b) of this section.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: January 4, 2001.

Robert A. Berenson, M.D.,

Acting Deputy Administrator, Health Care Financing Administration.

Approved: January 4, 2001.

Donna E. Shalala,

Secretary.

[FR Doc. 01–666 Filed 1–18–01; 11:49 am]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 1, 64 and 68

[WT Docket No. 99–217; CC Docket No. 96–98; CC Docket No. 88–57; FCC 00–366]

Promotion of Competitive Networks in Local Telecommunications Markets

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Commission takes actions to further competition in local communications markets by ensuring that competing telecommunications providers are able to provide services to customers in multiple tenant environments (MTEs). The actions that the Commission takes in this item will reduce the likelihood that incumbent local exchange carriers (LECs) can obstruct their competitors' access to MTEs, as well as address particular potentially anticompetitive actions by premises owners and other third parties.

DATES: The rule changes to 47 CFR 64.2500, 64.2501, and 64.2502, shall become effective March 12, 2001. The rule changes to 47 CFR 1.4000 and the rule changes amending the definition of the term ''demarcation point'' in 47 CFR 68.3 contain an information collection requirement that has not yet been approved by OMB; the FCC will publish a document in the **Federal Register** announcing the effective date of these rule changes. Comments from the public, OMB, and other agencies on the information collections contained in this document are due March 12, 2001.

ADDRESSES: A copy of any comments on the information collections contained herein should be submitted to Judy Boley, Federal Communications Commission, Room 1–C804, 445 12th Street, SW., Washington, DC 20554, or via the Internet to jboley@fcc.gov, and to Edward C. Springer, OMB Desk Officer, Room 10236 NEOB, 725 17th Street, NW., Washington, DC 20503 or via the Internet to edward.springer@omb.eop.gov.

FOR FURTHER INFORMATION CONTACT: Lauren Van Wazer at (202) 418–0030 or Joel Taubenblatt at (202) 418–1513 (Wireless Telecommunications Bureau). For additional information concerning the information collection(s) contained in this document, contact Judy Boley at 202–418–0214, or via the Internet at jboley@fcc.gov.

SUPPLEMENTARY INFORMATION: This is a summary of the First Report and Order in WT Docket No. 99–217, the Fifth Report and Order and Memorandum Opinion and Order in CC Docket No. 96–98, and the Fourth Report and Order and Memorandum Opinion and Order in CC Docket No. 88–57 (collectively, the ''Order''), FCC 00–366, adopted October 12, 2000 and released October 25, 2000. This summary also reflects errata issued in this proceeding subsequent to the release of this Order. The Commission seeks further comments on the issues in this proceeding in a Further Notice of Proposed Rulemaking, available at the addresses listed below and summarized separately in the **Federal Register**. The complete text of the document is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street, SW., Washington, DC, and also may be purchased from the Commission's copy contractor, International Transcription Services, (202) 857–3800, 445 12th Street, SW., CY–B400, Washington, D.C. 20554. This document is also available via the Internet at *http://fcc.gov/Bureaus/Wireless/Orders/2000/fcc00366.pdf.*

Paperwork Reduction Act

This Order contains a new information collection as described in Section D of the Final Regulatory Flexibility Analysis set forth below. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public, Office of Management and Budget (OMB), and other federal agencies to comment on the information collection(s) contained in this Order as required by the Paperwork Reduction Act of 1995, Public Law 104–13. It will be submitted to the OMB for review under section 3507(d) of the PRA. Public, OMB, and other agency comments are due March 12, 2001. Comments should address: (a) Whether the new collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimates; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

A copy of any comments on the information collections contained herein should be submitted to Judy Boley, Federal Communications Commission, Room 1–C804, 445 12th Street, SW., Washington, DC 20554, or via the Internet to jboley@fcc.gov, and to Edward C. Springer, OMB Desk Officer, Room 10236 NEOB, 725 17th Street, NW., Washington, DC 20503 or via the Internet to edward.springer@omb.eop.gov.

OMB Control Number: 3060–XXXX.

Title: Promotion of Competitive Networks in Local Telecommunications Markets; Wireless Communications Association International, Inc. Petition for Rulemaking to Amend section 1.4000 of the Commission's Rules to Preempt Restrictions on Subscriber Premises Reception or Transmission Antennas Designed to Provide Fixed Wireless Services; Implementation of the Local Competition Provisions in the Telecommunications Act of 1996; Review of Sections 68.104 and 68.213 of the Commission's Rules Concerning

Connection of Simple Inside Wiring to the Telephone Network

Form No.: NA.

Type of Review: New collection.

Respondents: Business or other for-profit.

Number of Respondents: 5983.

Estimated Time per Response: .5 hrs. for the first information collection, 10 hrs. for the second information collection.

Total Annual Burden: 571,350 hrs.

Total Annual Costs: $11,427,000.

Needs and Uses: The first information collection relates to the revisions of the Commission's demarcation point rules, 47 CFR 68.3. Under these revisions, the LEC shall make available information on the location of the demarcation point within ten business days of a request from the premises owner. In addition, at the time of installation, the LEC shall fully inform the premises owner of its options and rights regarding the placement of the demarcation point or points. The availability of this information will facilitate efficient interaction between premises owners and LECs regarding the placement of the demarcation point, which marks the end of wiring under control of the LEC and the beginning of wiring under the control of the premises owner or subscriber. The demarcation point is a critical point of interconnection where competitive LECs can gain access to the inside wiring of the building to provide service to customers in the building.

The second information collection relates to the revisions of the Commission's rules on Over-the-Air Reception Devices, 47 CFR 1.4000. Under these revisions, as a condition of invoking protection under 47 CFR 1.4000 from government, landlord, and association restrictions, a licensee must ensure that subscriber antennas are labeled to give notice of potential radiofrequency safety hazards of these antennas. Labeling information should include minimum separation distances required between users and radiating antennas to meet the Commission's radiofrequency exposure guidelines. Labels should also include reference to the Commission's applicable radiofrequency exposure guidelines and should use the ANSI-specified warning symbol for radiofrequency exposure. In addition, the instruction manuals and other information accompanying subscriber transceivers should include a full explanation of the labels, as well as a reference to the applicable Commission radiofrequency exposure guidelines.

Synopsis of Report and Order

1. In this document, the Commission took action furthering its ongoing efforts under the Telecommunications Act of 1996 to foster competition in local communications markets. The Commission implemented measures to enhance the ability of competing telecommunications providers to provide services to customers in residential and commercial buildings or other MTEs.

Discussion

2. In the Notice of Proposed Rulemaking in WT Docket No. 99–217, 64 FR 41887, August 2, 1999, and a Third Further Notice of Proposed Rulemking in CC Docket No. 96–98, 64 FR 41884, August 2, 1999 (together, ''Competitive Networks NPRM''), the Commission requested comment on the ability of competitive telecommunications providers to access MTEs and on a variety of potential measures to improve such access. Based on the extensive record compiled in response to the Competitive Networks NPRM, the Commission adopts the following four measures to remove obstacles to competitive access in MTEs:

- First, the Commission forbids telecommunications carriers from entering into contracts to serve commercial properties that restrict or effectively restrict the property owner's ability to permit entry by other carriers.
- Second, in order to reduce competitive carriers' dependence on the incumbent LECs to gain access to on-premises wiring, while at the same time recognizing the varied needs of carriers and building owners, the Commission establishes procedures to facilitate moving the demarcation point to the minimum point of entry (MPOE) at the building owner's request, and requires incumbent LECs to timely disclose the location of existing demarcation points where they are not located at the MPOE.
- Third, the Commission determines that under Section 224 of the Communications Act, utilities, including LECs, must afford telecommunications carriers and cable service providers reasonable and nondiscriminatory access to conduits and rights-of-way located in customer buildings and campuses, to the extent such conduits and rights-of-way are owned or controlled by the utility.
- Fourth, the Commission extends to antennas that receive and transmit telecommunications and other fixed wireless signals its existing prohibition of restrictions that impair the installation, maintenance or use of certain video antennas on property within the exclusive use or control of the antenna user, where the user has a direct or indirect ownership or leasehold interest in the property.

3. Contemporaneous with this document, the Commission is publishing a Further Notice of Proposed Rulemaking that seeks comment on several potential actions related to competition in MTEs. In addition, subsequent to this document, the Commission will publish a Report and Order (FCC 00–400) that steamlines and privatizes many of the functions in part 68 of the Commission's rules and, in connection with this streamlining, makes a nonsubstantive amendment to the part 68 demarcation point definition set forth.

Final Regulatory Flexibility Analysis

4. As required by the Regulatory Flexibility Act (RFA),[1] an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the Notice of Proposed Rulemaking in WT Docket No. 99–217 and Third Further Notice of Proposed Rulemaking in CC Docket No. 96–98, released July 7, 1999 (Competitive Networks NPRM).[2] The Commission sought written public comment on the proposals in the Competitive Networks NPRM, including comment on the IRFA. The comments received are discussed below. In addition, an IRFA was incorporated in the Second Further Notice of Proposed Rulemaking in CC Docket No. 88–57 (1997 Demarcation Point Order on Reconsideration).[3] This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[4]

A. Need for, and Objectives of, the Rules

4. In this Competitive Networks First Report and Order,[5] the Commission

[1] See 5 U.S.C. 603. The FRA, see 5 U.S.C. 601 *et seq.,* has been amended by the Contract With America Advancement Act of 1996, Public Law 104–121, 110 Stat. 847 (1996) (CWAAA). Title II of the CWAAA is the Small business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

[2] Promotion of Competitive Networks in Local Telecommunications Markets, Notice of Proposed Rulemaking and Notice of Inquiry in WT Docket No. 99–217, and Third Further Notice of Proposed Rulemaking in CC Docket No. 96–98, 14 FCC Red 12673, 12723–12734 (1999) (Competitive Networks NPRM).

[3] Review of Sections 68.104, and 68.213 of the Commission's Rules Concerning Connection of Simple Inside Wiring to the Telephone Network, Order on Reconsideration, Second Report and order and Second Further Notice of proposed Rulemaking, CC Docket No. 88–57, 12 FCC Red 11897, 11934–39 (1997) (1997 Demarcation Point Order on Reconsideration).

[4] See 5 U.S.C. 604.

[5] Promotion of Competitive Networks in Local Telecommunications Markets. First Report and Order, WT Docket No. 99–217, FCC 00–366

Continued

furthers its ongoing efforts under the Telecommunications Act of 1996[6] to foster competition in local communications markets by implementing measures to ensure that competing telecommunications providers are able to provide services to customers in multiple tenant environments (MTEs). MTEs include apartment buildings, office buildings, office parks, shopping centers, and manufactured housing communities. Based on the extensive record compiled in response to the Competitive Networks NPRM, the Commission adopts several measures to remove obstacles to competitive access in this important portion of the telecommunications market. Specifically the Commission: (1) Prohibits carriers from entering into contracts in commercial buildings that prevent access by competing carriers; (2) clarifies its demarcation point rules[7] governing control of in-building wiring and facilitates exercise of building owner options regarding that wiring; (3) concludes that the access mandated by section 224 of the Communications Act (the ''Pole Attachments Act'')[8] includes access to poles, ducts, conduits or rights-of-way that are owned or controlled by a utility within MTEs; and (4) concludes that tenants in MTEs should have the ability to place antennas one meter or less in diameter used to receive or transmit any fixed wireless service in areas within their exclusive use or control, and prohibits most restrictions on their ability to do so by extending the Commission's rules governing Over-the-Air Reception Devices (OTARDs).[9]

B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

5. Comments in response to the Competitive Networks NPRM IRFA were filed by the Community Associations Institute, *et al.* (CAI),[10] the National Association of Counties, *et al.* (NACO),[11] the Real Access Alliance (RAA),[12] and the Office of Advocacy of the U.S. Small Business Administration (SBA).[13]

6. CAI states that community associations (*i.e.,* condominiums, cooperatives and planned communities) would incur undue expense and disruptions if the Commission provides telecommunications carriers so-called ''forced access'' to association property.[14] Similarly, RAA states that the Commission's ''proposals will interfere with the ability of landlords to insure compliance with safety codes; provide for the safety of tenants, residents, and visitors; coordinate among tenants and service providers; and manage limited physical space.''[15] CAI requests that community associations be exempted from any ''forced access'' rules adopted by the Commission,[16] while RAA requests that all affected ''small businesses'' be exempted.[17] RAA also states that the Competitive Networks NPRM should be withdrawn and reissued with a revised IRFA.[18]

7. The actions taken in the Competitive Networks First Report and Order today do not impair the authority of property owners or managers, including community associations, under state law to exclude telecommunications carriers from their property.[19] Rather, the Competitive Networks First Report and Order makes clear that ''the right of access granted under section 224 lies only against utilities,''[20] as defined in section 224(a)(1) of the Act.[21] We also note that our authorization of small antennas for the provision of non-video services is limited to antennas situated on property under the control of a community association member rather than common property of the association, and therefore will not impose undue burdens or expense on community associations or small building owners.[22] CAI also states that prohibiting exclusive telecommunications contracts would adversely impact community associations.[23] The Competitive Networks First Report and Order does not prohibit such contracts for residential properties.[24] Accordingly, even assuming that such a prohibition would significantly impact community associations, no such impact will result from the actions taken in the Competitive Networks First Report and Order today.[25]

8. In its comments filed August 27, 1999, NACO states that the Commission's proposals ''for building owners and managers represent the federalizing of what is currently a growing local market in site leasing.''[26] We have deferred to the Competitive Networks Further Notice of Proposed Rulemaking (FNPRM) the issue of whether the Commission should impose a nondiscriminatory access requirement on building owners and managers.[27] NACO also states that ''[l]ocal communities would be * * * deprived of a revenue stream that could reduce local tax burdens * * *.''[28] In later filed comments, NACO reiterates its concern over ''the impact of lost right-of-way and tax revenues and the impact on infrastructure of loss of management control over the public right of way.''[29] Although we sought comment on issues related to access to public rights-of-way and franchise taxes in the Competitive Networks Notice of Inquiry, we take no action in this regard today.

9. SBA states that the IRFA ''inappropriately excludes small incumbent LECs from the definition of small business,'' and requests that the Commission reconcile its definition of small incumbent LEC with SBA's definition.[30] SBA states that, for RFA purposes, small incumbent LECs are not dominant in their field of operation because any such dominance is not ''national'' in scope.[31] In the

(adopted Oct. 12, 2000) (Competitive Networks First Report and Order)

[6] Telecommunications Act of 1996, Public law 104–104, 110 Stat. 56 codified at 47 U.S.C. 151 *et seq.* (1996 Act). The 1996 Act amended the Communications Act of 1934 (the ''Communications Act'' of the ''Act'' or the ''Act'').

[7] See 47 CFR 68.3

[8] 47 U.S.C. 224.

[9] See 47 CFR 1.4000.

[10] CAI IRFA Response (filed Aug 27, 1999).

[11] NACO IRFA Comments (filed Aug. 27, 1999) and NACO Comments (filed Oct. 12, 1999).

[12] RAA Joint Regulatory Flexibility Act Comments (filed Aug. 27, 1999).

[13] SBA Reply Comments (filed Sept. 10, 1999).

[14] CAI IRFA Response at 6–14.

[15] RAA Joint Regulatory Flexibility Act Comments at 7.

[16] CAI IRFA Response at 16–17.

[17] RAA Joint Regulatory Flexibility Act Comments at 8.

[18] *Id.* at 8–9.

[19] See Competitive Networks First Report and order, at paragraph 76 (''Section 224 was not intended to override whatever authority or control an MTE owners may otherwise retain under the terms of its agreements and state law.'').

[20] *Id.*

[21] 47 U.S.C. 224(a)(1).

[22] See Competitive Networks First Report and order, Section IV.E., *supra.*

[23] CAI IRFA Response at 14–15 (filed August 27, 1999).

[24] Competitive Networks First Report and Order, at paragraph 27.

[25] In Section V.A. of the Competitive Networks FNPRM, we seek comment on extending the prohibition on exclusive contracts to residential MTEs. Issues regarding the potential impact of such an action on small entities, including community associations, are discussed in the Competitive Networks FNPRM IRFA, *infra.*

[26] NACO IRFA Comments at 3 (filed Aug. 27, 1999).

[27] Competitive Networks FNPRM, Section V.A., *supra.*

[28] NACO IRFA Comments at 3 (filed Aug. 27, 1999).

[29] NACO Comments at 48 (filed Oct. 12, 1999).

[30] SBA Reply Comments at 3–4. (filed Sept. 10, 1999).

[31] *Id.* at 4. The Small Business Act contains a definition of ''small business concern,'' which the RFA incorporates into its own definition of ''small business.'' See 15 U.S.C. 632(a) (Small Business Act); 5 U.S.C. 601(3) (RFA). SBA regulations

Competitive Networks NPRM IRFA, we determined that, for the purposes of the IRFA, we would use the term ''small incumbent LECs'' to refer to incumbent LECs that might be defined by the SBA as small business concerns,[32] and would explicitly include small incumbent LECs in the analysis. In this present FRFA, *infra,* we have included small incumbent LECs within the definition of small business.

10. SBA and RAA separately state that the IRFA did not comply with the RFA. NACO concurs with RAA's comments in this regard. SBA states that ''[t]he Commission does not adequately discuss any significant economic impact its access proposal may have on small business nor does it propose sufficient alternatives that might minimize this impact, as is required by the RFA.'' [33] The Commission's access proposal included two key elements: (1) A requirement that building owners provide reasonable and nondiscriminatory access to their premises; and (2) a requirement, under Section 224 of the Act, that utilities provide telecommunications carriers access to their poles, ducts, conducts, and rights-of-way within buildings. As noted above, we are deferring to the Competitive Networks FNPRM the issue of whether and, if so, the extent to which, the Commission should impose a nondiscriminatory access requirement on building owners.[34] With respect to the proposed implementation of Section 224, in the Competitive Networks NPRM, we inquired:

> Whether an overly broad construction of utility ownership or control would impose unreasonable burdens on building owners, including small building owners, or compromise their ability to ensure the safe use of rights-of-way or conduit, or engender other practical difficulties.[35]

11. After a thorough review and analysis of the comments filed on our Section 224 proposal, we have determined that a broad definition of utility ownership or control would not best serve the public interest. Rather, in order to minimize the impact of our proposal on utilities (and the buildings that they serve) that must provide access to telecommunications carriers pursuant to section 224, we find that ''state law determines whether, and the extent to which, utility ownership or control of a right-of-way exists in any factual situation within the meaning of section 224.'' [36] The Competitive Networks First Report and Order, moreover, in no way impairs the authority under state law of building owners, including small building owners, to exclude telecommunications carriers from their property.[37]

12. In addition, we note that in the Competitive Networks NPRM IRFA we discussed certain alternatives that might have lessened the possible economic input on small entities. We stated:

> [W]ith respect to our Section 224 proposal, we seek comment on whether an overly broad construction of utility ownership or control would impose unreasonable burdens on building owners, including small building owners, or compromise their ability to ensure the safe use of rights-of-way or conduit, or engender other practical difficulties. In addition, with respect to our inquiry into building owner obligations, we seek comment on whether we should limit the scope of any building owner obligation in order to avoid imposing unreasonable regulatory burden on building owners, and we suggest that a potential rule could exempt buildings that house fewer than a certain number of tenants or are under a certain size.[38]

This discussion of alternatives included cross-references to the text of the Competitive Networks NPRM, to assist the reader. We note that the final rules that we adopt here will benefit small telecommunications carriers by fostering facilities-based competition. We also anticipate that our final rules will benefit small building owners and their tenants, by ensuring that utilities cannot block access to their rights-of-way.

13. SBA states that, while we suggested some alternatives to assist small entities in the IRFA, on the whole our efforts were ''inadequate.'' SBA states that a broader analysis was required, directed not only toward the alternatives described in the above paragraph but also toward alternatives for ''small LECs and the many other small businesses listed in the IRFA.'' [39] We find that we have met the requirements of the RFA. We chose reasonable alternatives to discuss, and did not discuss alternatives for every affected entity where it would not have seemed reasonable or, perhaps, where it simply did not occur to us. We believe that the RFA requires a good faith effort on our part, but it does not require a discussion of a minimum of four alternatives [40] for each of the possibly affected entities. As noted above, we specifically discussed one definitional issue and one possible exception, to assist small entities. We also sought comment from small entities on other issues throughout the Competitive Networks NPRM and IRFA. We appreciate the comments supplied by SBA and others as a result, and have considered them in the Competitive Networks First Report and Order and this IRFA.

14. Finally, RAA contends that the IRFA provided inadequate notice as a matter of law.[41] We note that the IRFA was sufficient to generate comments from representatives of the small business community and that the record demonstrates that the IRFA met the objectives of the RFA. Delaying issuance of final rules at this time would not, therefore, advance those objectives. The IRFA provided sufficient information so that the public could react to the Commission's proposal in the Competitive Networks NPRM in an informed manner. We note that, pursuant to the Administrative Procedure Act,[42] the Commission must provide ample opportunity for the public to comment on proposed rules. In this proceeding, the Commission provided a 37-day filing period or initial comments, followed by a 21-day period for reply comments. The public thus had nearly two months to provide comments. In addition, numerous parties filed *ex parte* statements with the Commission during the course of the 13-month period after the formal comment period closed. More than 1000 comments and other submissions were filed in this proceeding. Many of the commenters, including small businesses, enthusiastically endorsed

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interpret ''small business concern'' to include the concept of dominance on a national basis. 13 CFR 121.102(b). Since 1996, out of an abundance of caution, the Commission has included small incumbent LECs in its regulatory flexibility analyses. See, *e.g.,* Implementation of the Local Competition Provisions of the Telecommunications Act of 1996, CC Docket, 96–98, First Report and Order, 11 FCC Rcd 15499, 16144–45 (1996), 61 FR 45476 (Aug. 29, 1996).

[32] Competitive Networks NPRM IRFA, 14 FCC Rcd at 12726, paragraph 8. A ''small business'' under the RFA is one that, inter alia, meets the pertinent small business size standard (*e.g.,* a telephone communications business having 1,500 or fewer employees), and ''is not dominant in its field of operation.'' 5 U.S.C. 601(3).

[33] SBA Reply Comments at 4 (filed Sept. 10, 1999).

[34] Competitive Networks FNPRM, Section V.A., supra. In the Competitive Networks NPRM IRFA, we inquired ''whether we should limit the scope of any building owner obligation * * * [and noted] that a potential rule could exempt buildings that housed fewer than a certain number of tenants or are under a certain size.'' Competitive Networks NPRM IRFA, 14 FCC Rcd at 12733, paragraph 31.

[35] Competitive Networks NPRM, 14 FCC Rcd at 12697, paragraph 47.

[36] Competitive Networks First, Report an Order, at paragraph 87.

[37] See *id.*

[38] Competitive Networks NPRM IRFA, 14 FCC, Red at 12733, paragraph 31 (internal citations omitted).

[39] SBA Reply Comments at 2.

[40] See *id.* at 5.

[41] RAA Joint Regulatory Flexibility Act Comments at 3–5.

[42] See 5 U.S.C. 553.

the proposals in the Competitive Networks NPRM.

C. Description and Estimate of the Number of Small Entities to which the Rules Will Apply

15. The RFA requires that an initial regulatory flexibility analysis be prepared for notice-and-comment rulemaking proceedings, unless the agency certifies that ''the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.'' [43] The RFA generally defines ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' [44] In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act.[45] 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 Small Business Administration (SBA).[46] For many of the entities described below, we utilize SBA definitions of small business categories, which are based on Standard Industrial Classification (''SIC'') codes.

16. We have included small incumbent LECs in this present RFA analysis. As noted above, a ''small business'' under the RFA is one that, *inter alia,* meets the pertinent small business size standard (*e.g.,* a telephone communications business having 1,500 or fewer employees), and ''is not dominant in its field of operation.'' [47] The SBA contends that, for RFA purposes, small incumbent LECs are not dominant in their field of operation because any such dominance is not ''national'' in scope.[48] We have therefore included small incumbent LECs in this RFA analysis, although we emphasize that this RFA action has no effect on FCC analyses and determinations in other, non-RFA contexts.

17. This Competitive Networks First Report and Order adopts requirements that affect local exchange carriers and other utilities, building owners and managers, neighborhood associations, small governmental jurisdictions, cable operators, satellite providers, and wireless communications providers, as discussed below.

a. Local Exchange Carriers

18. The legal interpretation of section 224 set forth today, and the rule changes adopted today regarding exclusive contracts, demarcation point, and an extension of the OTARD rule will affect small LECs. Neither the Commission nor the SBA has developed a definition for small providers of local exchange services. The closest applicable definition under the SBA rules is for telephone communications companies other than radiotelephone (wireless) companies.[49] The SBA has defined establishments engaged in providing ''Telephone Communications, Except Radiotelephone'' to be small businesses when they have no more than 1,500 employees.[50] According to recent Telecommunications Industry Revenue data, 1,348 incumbent carriers reported that they were engaged in the provision of local exchange services.[51] We do not have data specifying the number of these carriers that are either dominant in their field of operations, are not independently owned and operated, or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of LECs that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that fewer than 1,348 providers of local exchange service are small entities or small incumbent LECs that may be affected by the rules and policies adopted today.

b. Other Utilities

19. The legal interpretation of section 224 set forth today will affect utilities other than LECs. Section 224 defines a ''utility'' as ''any person who is a local exchange carrier or an electric, gas, water, steam, or other public utility, and who owns or controls poles, ducts, conduits, or rights-of-way used, in whole or in part, for any wire communications. Such term does not include any railroad, any person who is cooperatively organized, or any person owned by the Federal Government or any state.'' The Commission anticipates that, to the extent its legal interpretation of Section 224 affects non-LEC utilities, the effect would be concentrated on electric utilities.

(1) *Electric Utilities (SIC 4911, 4931 and 4939).* 20. *Electric Services (SIC 4911).* The SBA has developed a definition for small electric utility firms.[52] The Census Bureau reports that a total of 1,379 electric utilities were in operation for at least one year at the end of 1992. According to SBA, a small electric utility is an entity whose gross revenues do not exceed five million dollars.[53] The Census Bureau reports that 447 of the 1,379 firms listed had total revenues below five million dollars in 1992.[54]

21. *Electric and Other Services Combined (SIC 4931).* The SBA has classified this entity as a utility whose business is less than 95% electric in combination with some other type of service.[55] The Census Bureau reports that a total of 135 such firms were in operation for at least one year at the end of 1992. The SBA's definition of a small electric and other services combined utility is a firm whose gross revenues do not exceed five million dollars.[56] The Census Bureau reported that 45 of the 135 firms listed had total revenues below five million dollars in 1992.[57]

22. *Combination Utilities, Not Elsewhere Classified (SIC 4939).* The SBA defines this type of utility as providing a combination of electric, gas, and other services that are not otherwise classified.[58] The Census Bureau reports that a total of 79 such utilities were in operation for at least one year at the end

[43] 5 U.S.C. 605(b).

[44] 5 U.S.C. 601(6).

[45] 5 U.S.C. 601(3) (incorporating by reference the definition of ''small business concern'' in Small Business Act, 15 U.S.C. 632). Pursuant to 5 U.S.C. 601(3), the statutory definition of a small business applies ''unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the **Federal Register**.''

[46] Small Business Act, 15 U.S.C. 632.

[47] 5 U.S.C. 601(3).

[48] SBA Reply Comments at 3–4. See also Letter from Jere W. Glover, Chief Counsel for Advocacy, SBA, to William E. Kennard, Chairman, FCC (May 27, 1999). The Small Business Act contains a definition of ''small business concern,'' which the RFA incorporates into its own definition of ''small business.'' See 15 U.S.C. 632(a) (Small Business Act); 5 U.S.C. 601(3) (RFA). SBA regulations interpret ''small business concern'' to include the concept of dominance on a national basis. 13 CFR 121.102(b). Since 1996, out of an abundance of caution, the Commission has included small incumbent LECs in its regulatory flexibility analyses. See, *e.g.,* Implementation of the Local Competition Provisions of the Telecommunications Act of 1996, CC Docket, 96–98, First Report and Order, 11 FCC Rcd 15499, 16144–45 (1996), 61 FR 45476 (Aug. 29, 1996).

[49] See 13 CFR 121.201, SIC Code 4813.

[50] 13 CFR 121.201. See Executive Office of the President, Office of Management and Budget, Standard Industrial Classification Manual (1987) (1987 SIC Manual).

[51] FCC, Common Carrier Bureau, Industry Analysis Division, Trends in Telephone Service, Table 19.3 (March 2000)

[52] 1987 SIC Manual.

[53] 53 13 CFR 121.201.

[54] U.S. Department of Commerce, Bureau of the Census, 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D (Bureau of Census data under contract to the Office of Advocacy of the SBA) (1992 Economic Census Industry and Enterprise Receipts Size Report).

[55] 1987 SIC Manual.

[56] 13 CFR 121.201.

[57] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[58] 1987 SIC Manual.

of 1992. According to SBA's definition, a small combination utility is a firm whose gross revenues do not exceed five million dollars.[59] The Census Bureau reported that 63 of the 79 firms listed had total revenues below five million dollars in 1992.[60]

(2) *Gas Production and Distribution (SIC 4922, 4923, 4924, 4925 and 4932).* 23. *Natural Gas Transmission (SIC 4922).* The SBA's definition of a natural gas transmitter is an entity that is engaged in the transmission and storage of natural gas.[61] The Census Bureau reports that a total of 144 such firms were in operation for at least one year at the end of 1992. According to SBA's definition, a small natural gas transmitter is an entity whose gross revenues do not exceed five million dollars.[62] The Census Bureau reported that 70 of the 144 firms listed had total revenues below five million dollars in 1992.[63]

24. *Natural Gas Transmission and Distribution (SIC 4923).* The SBA has classified this type of entity as a utility that transmits and distributes natural gas for sale.[64] The Census Bureau reports that a total of 126 such entities were in operation for at least one year at the end of 1992. The SBA's definition of a small natural gas transmitter and distributor is a firm whose gross revenues do not exceed five million dollars.[65] The Census Bureau reported that 43 of the 126 firms listed had total revenues below five million dollars in 1992.[66]

25. *Natural Gas Distribution (SIC 4924).* The SBA defines a natural gas distributor as an entity that distributes natural gas for sale.[67] The Census Bureau reports that a total of 478 such firms were in operation for at least one year at the end of 1992. According to the SBA, a small natural gas distributor is an entity whose gross revenues do not exceed five million dollars.[68] The Census Bureau reported that 267 of the 478 firms listed had total revenues below five million dollars in 1992.[69]

26. *Mixed, Manufactured, or Liquefied Petroleum Gas Production and/or Distribution (SIC 4925).* The SBA has classified this type of entity as a utility that engages in the manufacturing and/or distribution of the sale of gas.[70] These mixtures may include natural gas. The Census Bureau reports that a total of 43 such firms were in operation for at least one year at the end of 1992. The SBA's definition of a small mixed, manufactured or liquefied petroleum gas producer or distributor is a firm whose gross revenues do not exceed five million dollars.[71] The Census Bureau reported that 31 of the 43 firms listed had total revenues below five million dollars in 1992.[72]

27. *Gas and Other Services Combined (SIC 4932).* The SBA has classified this entity as a gas company whose business is less than 95% gas, in combination with other services.[73] The Census Bureau reports that a total of 43 such firms were in operation for at least one year at the end of 1992. According to the SBA, a small gas and other services combined utility is a firm whose gross revenues do not exceed five million dollars.[74] The Census Bureau reported that 24 of the 43 firms listed had total revenues below five million dollars in 1992.[75]

(3) *Water Supply (SIC 4941).*

28. The SBA defines a water utility as a firm who distributes and sells water for domestic, commercial and industrial use.[76] The Census Bureau reports that a total of 3,169 water utilities were in operation for at least one year at the end of 1992. According to SBA's definition, a small water utility is a firm whose gross revenues do not exceed five million dollars.[77] The Census Bureau reported that 3,065 of the 3,169 firms listed had total revenues below five million dollars in 1992.[78]

(4) *Sanitary Systems (SIC 4952, 4953 & 4959).*

29. *Sewerage Systems (SIC 4952).* The SBA defines a sewage firm as a utility whose business is the collection and disposal of waste using sewage systems.[79] The Census Bureau reports that a total of 410 such firms were in operation for at least one year at the end of 1992. According to SBA's definition, a small sewerage system is a firm whose gross revenues did not exceed five million dollars.[80] The Census Bureau reported that 369 of the 410 firms listed had total revenues below five million dollars in 1992.[81]

30. *Refuse Systems (SIC 4953).* The SBA defines a firm in the business of refuse as an establishment whose business is the collection and disposal of refuse ''by processing or destruction or in the operation of incinerators, waste treatment plants, landfills, or other sites for disposal of such materials.''[82] The Census Bureau reports that a total of 2,287 such firms were in operation for at least one year at the end of 1992. According to SBA's definition, a small refuse system is a firm whose gross revenues do not exceed six million dollars.[83] The Census Bureau reported that 1,908 of the 2,287 firms listed had total revenues below six million dollars in 1992.[84]

31. *Sanitary Services, Not Elsewhere Classified (SIC 4959).* The SBA defines these firms as engaged in sanitary services.[85] The Census Bureau reports that a total of 1,214 such firms were in operation for at least one year at the end of 1992. According to SBA's definition, a small sanitary service firm's gross revenues do not exceed five million dollars.[86] The Census Bureau reported that 1,173 of the 1,214 firms listed had total revenues below five million dollars in 1992.[87]

(5) *Steam and Air Conditioning Supply (SIC 4961).* 32. The SBA defines a steam and air conditioning supply utility as a firm who produces and/or sells steam and heated or cooled air.[88] The Census Bureau reports that a total of 55 such firms were in operation for at least one year at the end of 1992. According to SBA's definition, a steam and air conditioning supply utility is a firm whose gross revenues do not exceed nine million dollars.[89] The Census Bureau reported that 30 of the 55 firms listed had total revenues below nine million dollars in 1992.[90]

(6) *Irrigation Systems (SIC 4971).* 33. The SBA defines irrigation systems as firms who operate water supply systems

[59] 13 CFR 121.201.

[60] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[61] 1987 SIC Manual.

[62] 13 CFR 121.201.

[63] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[64] 1987 SIC Manual.

[65] 65 13 CFR 121.201.

[66] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[67] 1987 SIC Manual.

[68] 13 CFR 121.201.

[69] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[70] 1987 SIC Manual.

[71] 13 CFR 121.201.

[72] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[73] 1987 SIC Manual.

[74] 13 CFR 121.201.

[75] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[76] 1987 SIC Manual.

[77] 13 CFR 121.201.

[78] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[79] 1987 SIC Manual.

[80] 13 CFR 121.201.

[81] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[82] 1987 SIC Manual.

[83] 13 CFR 121.201.

[84] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[85] 1987 SIC Manual.

[86] 13 CFR 121.201.

[87] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[88] 1987 SIC Manual.

[89] 13 CFR 121.201.

[90] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

for the purpose of irrigation.[91] The Census Bureau reports that a total of 297 firms were in operation for at least one year at the end of 1992. According to SBA's definition, a small irrigation service is a firm whose gross revenues do not exceed five million dollars.[92] The Census Bureau reported that 286 of the 297 firms listed had total revenues below five million dollars in 1992.[93]

c. Building Owners and Managers

34. The rule changes adopted today will affect multiple dwelling unit operators and real estate agents and managers.

(1) *Multiple Dwelling Unit Operators (SIC 6512, SIC 6513, SIC 6514).*

35. The SBA has developed definitions of small entities for operators of nonresidential buildings, apartment buildings, and dwellings other than apartment buildings, which include all such companies generating $5 million or less in revenue annually.[94] According to the Census Bureau, there were 26,960 operators of nonresidential buildings generating less than $5 million in revenue that were in operation for at least one year at the end of 1992.[95] Also according to the Census Bureau, there were 39,903 operators of apartment dwellings generating less than $5 million in revenue that were in operation for at least one year at the end of 1992.[96] The Census Bureau provides no separate data regarding operators of dwellings other than apartment buildings, and we are unable at this time to estimate the number of such operators that would qualify as small entities.

(2) *Real Estate Agents and Managers (SIC 6531).*

36. The SBA defines real estate agents and managers as establishments primarily engaged in renting, buying, selling, managing, and appraising real estate for others.[97] According to SBA's definition, a small real estate agent or manager is a firm whose revenues do not exceed 1.5 million dollars.[98]

d. Neighborhood Associations

37. The extension of the OTARD rules adopted today will affect neighborhood associations. The Regulatory Flexibility Act defines ''small organization'' as ''any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.'' [99] This definition includes homeowner and condominium associations that operate as not-for-profit organizations. The Community Associations Institute estimates that there are 205,000 such associations.[100]

e. Municipalities

38. The extension of the OTARD rules adopted today will affect neighborhood associations. The term ''small governmental jurisdiction'' is defined as ''governments of * * * districts, with a population of less than 50,000.'' [101] As of 1992, there were approximately 85,006 governmental entities in the United States.[102] This number includes such entities as states, counties, cities, utility districts and school districts. Of the 85,006 governmental entities, 38,978 are counties, cities and towns. The remainder are primarily utility districts, school districts, and states. Of the 38,978 counties, cities and towns, 37,566, or 96%, have populations of fewer than 50,000.[103] The Census Bureau estimates that this ratio is approximately accurate for all governmental entities. Thus, of the 85,006 governmental entities, we estimate that 81,606 (96%) are small entities.

f. Cable Services or Systems

39. The SBA has developed a definition of small entities for cable and other pay television services, which includes all such companies generating $11 million or less in revenue annually.[104] This definition includes cable systems operators, closed circuit television services, direct broadcast satellite services, multipoint distribution systems, satellite master antenna systems and subscription television services. According to the Census Bureau data from 1992, there were 1,788 total cable and other pay television services and 1,423 had less than $11 million in revenue.[105]

40. The Commission has developed its own definition of a small cable system operator for purposes of rate regulation. Under the Commission's rules, a ''small cable company'' is one serving fewer than 400,000 subscribers nationwide.[106] Based on our most recent information, we estimate that there were 1,439 cable operators that qualified as small cable system operators at the end of 1995.[107] Since then, some of those companies may have grown to serve over 400,000 subscribers, and others may have been involved in transactions that caused them to be combined with other cable operators. Consequently, we estimate that there are fewer than 1,439 small entity cable system operators.

41. The Communications Act also contains a definition of a small cable system operator, which is ''a cable operator that, directly or through an affiliate, serves in the aggregate fewer than 1 percent of all subscribers in the United States and is not affiliated with any entity or entities whose gross annual revenues in the aggregate exceed $250,000,000.'' [108] The Commission has determined that there are 66,690,000 subscribers in the United States. Therefore, we found that an operator serving fewer than 666,900 subscribers shall be deemed a small operator, if its annual revenues, when combined with the total annual revenues of all of its affiliates, do not exceed $250 million in the aggregate.[109] Based on available data, we find that the number of cable operators serving 666,900 subscribers or less totals 1,450.[110] We do not request nor do we collect information concerning whether cable system operators are affiliated with entities whose gross annual revenues exceed $250,000,000,[111] and thus are unable at this time to estimate with greater precision the number of cable system operators that would qualify as small

[91] 1987 SIC Manual.

[92] 13 CFR 121.201.

[93] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D.

[94] 13 CFR 121.601 (SIC 6512, SIC 6513, SIC 6514).

[95] 1992 Economic Census of Financial, Insurance and Real Estate Industries, Establishment and Firm Size Report, Table 4, SIC 6512 (U.S. Bureau of the Census data under contract to the Office of Advocacy of the U.S. Small Business Administration) (1992 Economic Census of Financial, Insurance and Real Estate Industries, Establishment and Firm Size Report).

[96] 1992 Economic Census of Financial, Insurance and Real Estate Industries, Establishment and Firm Size Report, Table 4, SIC 6513.

[97] 1987 SIC Manual.

[98] 13 CFR 121.201.

[99] See 5 U.S.C. 601(4).

[100] CAI IRFA Response at 5 (filed Aug. 27, 1999).

[101] 5 U.S.C. 601(5).

[102] U.S. Department of Commerce, Bureau of the Census, ''1992 Census of Governments.''

[103] *Id.*

[104] 13 CFR 121.201, SIC code 4841.

[105] **1992 Economic Census Industry and Enterprise Receipts Size Report,** Table 2D, SIC code 4841 (U.S. Bureau of the Census data under contract to the Office of Advocacy of the U.S. Small Business Administration).

[106] 47 CFR 76.901(e). The Commission developed this definition based on its determination that a small cable system operator is one with annual revenues of $100 million or less. Implementation of Sections of the 1992 Cable Act: Rate Regulation, Sixth Report and Order and Eleventh Order on Reconsideration, 10 FCC Rcd 7393 (1995), 60 FR 10534 (Feb. 27, 1995).

[107] Paul Kagan Associates, Inc., Cable TV Investor, Feb. 29, 1996 (based on figures for Dec. 30, 1995).

[108] 47 U.S.C. 543(m)(2).

[109] 47 CFR 76.1403(b).

[110] Paul Kagan Associates, Inc., Cable TV Investor, Feb. 29, 1996 (based on figures for Dec. 30, 1995).

[111] We do receive such information on a case-by-case basis only if a cable operator appeals a local franchise authority's finding that the operator does not qualify as a small cable operator pursuant to Section 76.1403(b) of the Commission's Rules. See 47 CFR 76.1403(d).

cable operators under the definition in the Communications Act.

g. International Services

42. The Commission has not developed a definition of small entities applicable to licensees in the international services. Therefore, the applicable definition of small entity is generally the definition under the SBA rules applicable to Communications Services, Not Elsewhere Classified (NEC).[112] This definition provides that a small entity is expressed as one with $11.0 million or less in annual receipts.[113] According to the Census Bureau, there were a total of 848 communications services providers, NEC, in operation in 1992, and a total of 775 had annual receipts of less than $9.999 million.[114] The Census report does not provide more precise data.

43. *International Broadcast Stations.* Commission records show that there are 20 international broadcast station licensees. We do not request or collect annual revenue information, and thus are unable to estimate the number of international broadcast licensees that would constitute a small business under the SBA definition. However, the Commission estimates that only six international broadcast stations are subject to regulatory fee payments.

44. *International Public Fixed Radio (Public and Control Stations).* There are 3 licensees in this service subject to payment of regulatory fees. We do not request or collect annual revenue information, and thus are unable to estimate the number of international broadcast licensees that would constitute a small business under the SBA definition.

45. *Fixed Satellite Transmit/Receive Earth Stations.* There are approximately 2,679 earth station authorizations, a portion of which are Fixed Satellite Transmit/Receive Earth Stations. We do not request or collect annual revenue information, and thus are unable to estimate the number of the earth stations that would constitute a small business under the SBA definition.

46. *Fixed Satellite Small Transmit/Receive Earth Stations.* There are approximately 2,679 earth station authorizations, a portion of which are Fixed Satellite Small Transmit/Receive Earth Stations. We do not request or collect annual revenue information, and thus are unable to estimate the number of fixed satellite transmit/receive earth stations that would constitute a small business under the SBA definition.

47. *Mobile Satellite Earth Stations.* There are 11 licensees. We do not request or collect annual revenue information, and thus are unable to estimate the number of mobile satellite earth stations that would constitute a small business under the SBA definition.

48. *Radio Determination Satellite Earth Stations.* There are four licensees. We do not request or collect annual revenue information, and thus are unable to estimate the number of radio determination satellite earth stations that would constitute a small business under the SBA definition.

49. *Direct Broadcast Satellites.* Because DBS provides subscription services, DBS falls within the SBA-recognized definition of ''Cable and Other Pay Television Services.''[115] This definition provides that a small entity is one with $11.0 million or less in annual receipts.[116] As of December 1996, there were eight DBS licensees. However, the Commission does not collect annual revenue data for DBS and, therefore, is unable to ascertain the number of small DBS licensees that would be impacted by these proposed rules. Although DBS service requires a great investment of capital for operation, there are several new entrants in this field that may not yet have generated $11 million in annual receipts, and therefore may be categorized as small businesses, if independently owned and operated.

50. *Fixed Satellite Very Small Aperture Terminal (VSAT) Systems.* These stations operate on a primary basis, and frequency coordination with terrestrial microwave systems is not required. Thus, a single ''blanket'' application may be filed for a specified number of small antennas and one or more hub stations. The Commission has processed 377 applications. We do not request nor collect annual revenue information, and thus are unable to estimate the number of VSAT systems that would constitute a small business under the SBA definition.

h. Multipoint Distribution Service (MDS)

51. MDS involves a variety of transmitters, which are used to relay programming to the home or office, similar to that provided by cable television systems.[117] In connection with the 1996 MDS auction, the Commission defined small businesses as entities that had annual average gross revenues for the three preceding years not in excess of $40 million.[118] This definition of a small entity in the context of MDS auctions has been approved by the SBA.[119] These stations were licensed prior to implementation of Section 309(j) of the Communications Act of 1934, as amended.[120] Licenses for new MDS facilities are now awarded to auction winners in Basic Trading Areas (BTAs) and BTA-like areas.[121] The MDS auctions resulted in 67 successful bidders obtaining licensing opportunities for 493 BTAs. Of the 67 auction winners, 61 meet the definition of a small business. There are 2,050 MDS stations currently licensed. Thus, we conclude that there are 1,634 MDS providers that are small businesses as deemed by the SBA and the Commission's auction rules.

i. Wireless Services

52. *Broadband Personal Communications Service (PCS).* The broadband PCS spectrum is divided into six frequency blocks designated A through F, and the Commission has held auctions for each block. The Commission defined ''small entity'' for Blocks C and F as an entity that has average gross revenues of $40 million or less in the three previous calendar years.[122] For Block F, an additional classification for ''very small business'' was added and is defined as an entity that, together with its affiliates, has average gross revenues of not more than $15 million for the preceding three calendar years.[123] These regulations defining ''small entity'' in the context of broadband PCS auctions have been

[112] An exception is the Direct Broadcast Satellite (DBS) Service, *infra.*

[113] 13 CFR 120.121, SIC code 4899.

[114] 1992 Economic Census Industry and Enterprise Receipts Size Report, Table 2D, SIC code 4899 (U.S. Bureau of the Census data under contract to the Office of Advocacy of the U.S. Small Business Administration).

[115] 13 CFR 120.121, SIC code 4841.

[116] 13 CFR 121.201, SIC code 4841.

[117] For purposes of this item, MDS includes both the single channel Multipoint Distribution Service (MDS) and the Multichannel Multipoint Distribution Service (MMDS).

[118] 47 CFR 1.2110 (a)(1).

[119] Amendment of parts 21 and 74 of the Commission's Rules with Regard to Filing Procedures in the Multipoint Distribution Service and in the Instructional Television Fixed Service and Implementation of Section 309(j) of the Communications Act—Competitive Bidding, 10 FCC Rcd 9589 (1995), 60 FR 36524 (Jul. 17, 1995).

[120] 47 U.S.C. 309(j).

[121] *Id.* A Basic Trading Area (BTA) is the geographic area by which the Multipoint Distribution Service is licensed. See Rand McNally 1992 Commercial Atlas and Marketing Guide, 123rd Edition, pp. 36–39.

[122] See Amendment of parts 20 and 24 of the Commission's Rules—Broadband PCS Competitive Bidding and the Commercial Mobile Radio Service Spectrum Cap, WT Docket No. 96–59; Amendment of the Commission's Cellular/PCS Cross-Ownership Rule, GN Docket 90–314, Report and Order, 11 FCC Rcd 7824, 7850–52, paragraphs 57–60 (1996) (*Cross Ownership Report & Order*); see also 47 CFR 24.720(b).

[123] Cross Ownership Report & Order, 11 FCC Rcd at 7852, paragraph 60.

approved by the SBA.[124] No small businesses within the SBA-approved definition bid successfully for licenses in Blocks A and B. There were 90 winning bidders that qualified as small entities in the Block C auctions. A total of 93 small and very small business bidders won approximately 40 percent of the 1,479 licenses for Blocks D, E, and F.[125] Based on this information, we conclude that the number of small broadband PCS licensees will include the 90 winning C Block bidders and the 93 qualifying bidders in the D, E, and F blocks, for a total of 183 small entity PCS providers as defined by the SBA and the Commission's auction rules.

53. *Cellular Licensees.* Neither the Commission nor the SBA has developed a definition of small entities applicable to cellular licensees. Therefore, the applicable definition of a small entity is the definition under the SBA rules applicable to radiotelephone (wireless) companies. This provides that a small entity is a radiotelephone company employing no more than 1,500 persons.[126] According to the Bureau of the Census, only twelve radiotelephone firms from a total of 1,178 such firms that operated during 1992 had 1,000 or more employees.[127] Therefore, even if all twelve of these firms were cellular telephone companies, nearly all cellular carriers were small businesses under the SBA's definition. In addition, we note that there are 1,758 cellular licenses; however, a cellular licensee may own several licenses. In addition, according to the most recent Trends in Telephone Service data, 808 carriers reported that they were engaged in the provision of either cellular service, Personal Communications Service (PCS), or Specialized Mobile Radio Telephone (SMR) service, which are placed together in the data.[128] We do not have data specifying the number of these carriers that are not independently owned and operated or have more than 1,500 employees, and thus are unable at this time to estimate with greater precision the number of cellular service carriers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 808 or fewer small cellular service carriers that may be affected by any regulations adopted pursuant to this proceeding.

54. *Fixed Microwave Services.* Microwave services include common carrier,[129] private-operational fixed,[130] and broadcast auxiliary radio services.[131] At present, there are approximately 22,015 common carrier fixed licensees and 61,670 private operational-fixed licensees and broadcast auxiliary radio licensees in the microwave services. The Commission has not yet defined a small business with respect to microwave services. For purposes of this IRFA, we will utilize the SBA's definition applicable to radiotelephone companies—*i.e.,* an entity with no more than 1,500 persons.[132] We estimate, for this purpose, that all of the Fixed Microwave licensees (excluding broadcast auxiliary licensees) would qualify as small entities under the SBA definition for radiotelephone companies.

55. *Rural Radiotelephone Service.* The Commission has not adopted a definition of small entity specific to the Rural Radiotelephone Service.[133] A significant subset of the Rural Radiotelephone Service is the Basic Exchange Telephone Radio Systems (BETRS).[134] We will use the SBA's definition applicable to radiotelephone companies, *i.e.,* an entity employing no more than 1,500 persons.[135] There are approximately 1,000 licensees in the Rural Radiotelephone Service, and we estimate that almost all of them qualify as small entities under the SBA's definition.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

56. The Competitive Networks First Report and Order requires incumbent LECs to respond promptly to requests by building owners to identify the location of the demarcation point. The Competitive Networks First Report and Order holds that if an incumbent LEC fails to produce this information within ten business days of the request, the premises owner may presume the demarcation point to be located at the minimum point of entry (MPOE).[136] The Competitive Networks First Report and Order further requires that where LECs do not establish a practice of placing the demarcation point at the MPOE, they fully inform building owners, at the time of installation, of their options regarding placement.

57. The Competitive Networks First Report and Order holds that in order to further competition, a request by a property owner to relocate the demarcation point to the MPOE must be addressed by an incumbent LEC in a reasonably timely and fair manner, so as not to unduly delay or hinder competitive LEC access. The Competitive Networks First Report and Order therefore directs incumbent LECs to conclude negotiations with requesting building owners within 45 days of such a request.

58. In addition, the Competitive Networks First Report and Order requires, as a condition of invoking protection under the OTARD rule from government, landlord and association restrictions, that licensees ensure that subscriber antennas be labeled to give notice of potential radiofrequency safety hazards of antennas used for fixed wireless transmissions. Labeling information should include minimum separation distances required between users and radiating antennas to meet the Commission's radiofrequency exposure guidelines. Labels should also include reference to the Commission's applicable radiofrequency exposure guidelines. In addition, the instruction manuals and other information accompanying subscriber transceivers should include a full explanation of the labels, as well as a reference to the applicable Commission radiofrequency exposure guidelines.

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[124] See, *e.g.,* Implementation of Section 309(j) of the Communications Act—Competitive Bidding, PP Docket No. 93–253, Fifth Report and Order, 9 FCC Rcd 5532, 5581–84, paragraphs 114–20 (1994).

[125] FCC News, Broadband PCS, D, E and F Block Auction Closes, No. 71744 (rel. Jan. 14, 1997).

[126] 13 CFR 121.201, SIC code 4812.

[127] 1992 Census, Series UC92–S–1, at Table 5, SIC code 4812.

[128] FCC, Common Carrier Bureau, Industry Analysis Division, Trends in Telephone Service, Table 19.3 (March 2000).

[129] 47 CFR 101 *et seq.* (formerly, part 21 of the Commission's Rules).

[130] Persons eligible under parts 80 and 90 of the Commission's rules can use Private Operational-Fixed Microwave services. See 47 CFR parts 80 and 90. Stations in this service are called operational-fixed to distinguish them from common carrier and public fixed stations. Only the licensee may use the operational-fixed station, and only for communications related to the licensee's commercial, industrial, or safety operations.

[131] Auxiliary Microwave Service is governed by part 74 of Title 47 of the Commission's Rules. See 47 CFR 74 *et seq.* Available to licensees of broadcast stations and to broadcast and cable network entities, broadcast auxiliary microwave stations are used for relaying broadcast television signals from the studio to the transmitter, or between two points such as a main studio and an auxiliary studio. The service also includes mobile TV pickups, which relay signals from a remote location back to the studio.

[132] 13 CFR 121.201, SIC 4812.

[133] The service is defined in section 22.99 of the Commission's Rules, 47 CFR 22.99.

[134] BETRS is defined in sections 22.757 and 22.759 of the Commission's Rules, 47 CFR 22.757 and 22.759.

[135] 13 CFR 121.201, SIC code 4812.

[136] The minimum point of entry is defined as ''either the closest practicable point to where the wiring crosses a property line or the closest practicable point to where the wiring enters a multiunit building or buildings.'' 47 CFR 68.3 (definition of demarcation point).

E. Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered.

59. The rule changes adopted in this Competitive Networks First Report and Order are intended to promote competition in local communications markets by implementing measures to ensure that competing telecommunications providers are able to provide services to customers in MTEs. The actions taken today will benefit consumers, telecommunications carriers, and building owners, including small entities.

60. In the Competitive Networks NPRM, we sought comment on seven proposals: (1) The tentative conclusion that, to the extent that LECs or other utilities own or control rooftop and other rights-of-way or riser conduit in MTEs, section 224 of the Act[137] requires that they permit competing providers access to such rights-of-way or conduit under just, reasonable and nondiscriminatory rates, terms, and conditions; (2) whether we should require incumbent LECs to make available to any requesting telecommunications carrier unbundled access to riser cable and wiring that they control within MTEs, subject to the Commission's future interpretation of the ''necessary'' and ''impair'' standards of section 251 of the Act;[138] (3) whether we should require building owners, who allow access to their premises to any telecommunications provider, to make comparable access available to all such providers on a nondiscriminatory basis; (4) whether we should forbid telecommunications service providers, under some or all circumstances, from entering into exclusive contracts with building owners, and abrogate any existing exclusive contracts between these parties; (5) whether we should modify our rules governing determination of the demarcation point between facilities controlled by the telephone company and by the landowner on multiple unit premises; (6) whether the rules governing access to cable home wiring for multichannel video program distribution should be extended to benefit providers of telecommunications services; and (7) whether we should adopt rules similar to those adopted in the video context under section 207 of the 1996 Act protecting the ability to place antennas to transmit and receive telecommunications signals and other signals that are not covered under section 207. After careful review and analysis of the voluminous record developed in response to the Competitive Networks NPRM, we take action on four proposals today.

61. First, we prohibit telecommunications service providers from entering into exclusive contracts to serve commercial buildings. In the Competitive Networks NPRM, we solicited comment on this proposal as an alternative to our proposal to require building owners to provide nondiscriminatory access to their premises to telecommunications providers.[139] As noted above, we received comment opposed to this second alternative. We have not adopted the latter proposal in the Competitive Networks First Report and Order; however, we do seek additional comment on it in the Competitive Networks FNPRM.[140] In the Competitive Networks NPRM, we also inquired whether we should abrogate existing exclusive contracts.[141] Based on the record in this proceeding, we have determined that abrogating exclusive contracts may interfere with the investment-backed expectations of the parties to such contracts, including small entities, and thus we defer consideration of this issue to the Competitive Networks FNPRM.[142] We also find that the record is not sufficiently developed to determine whether the prohibition on exclusive contracts should apply to residential MTEs,[143] and therefore defer this issue to the Competitive Networks FNPRM.[144] We note that there was widespread support in the record for prohibiting future exclusive contracts in commercial MTEs.[145] We also note our expectation that small entities, including small telecommunications carriers and small building owners, will benefit from the competitive telecommunications environment that the ban on exclusive contracts will foster.

62. Second, with respect to to modifying the Commission's demarcation point rules, we sought comment on, *inter alia*, establishing a uniform demarcation point at the minimum point of entry (MPOE) to multiple unit premises.[146] We have weighed the evidence in the record concerning this proposal carefully. We find that the potential financial burden of moving the demarcation point to the MPOE and the fact that it may hinder deployment of facilities by carriers, including small entities, which utilize unbundled local loops outweigh the potential benefits of adopting this proposal.[147] In the alternative, we take the following actions to promote access to telecommunications wiring by competing carriers, including small entities: (1) We clarify that the Commission's demarcation point rules govern the control of inside wiring and related facilities for purposes of competitive access, as well as the control of these facilities for purposes of installation and maintenance; (2) we require that incumbent LECs conclude negotiations with building owners to relocate the demarcation point to the MPOE within 45 days of the building owner's request; and (3) we require that incumbent LECs fulfill their duty to disclose the location of the demarcation point, where it is not located at the MPOE, within ten business days of a building owner's request.[148] Collectively, these actions ''will substantially reduce the potential for incumbent LECs to obstruct competitive access to MTEs,''[149] while imposing only minimal financial burdens. We expect that that many smaller carriers seeking competitive entry will benefit directly from these actions.

63. Third, we have adopted our proposal under section 224 of the Act[150] to require LECs and other utilities which own or control poles, ducts, conduits and other rights-of-way in MTEs, to permit competing providers access to such facilities under just, reasonable and nondiscriminatory rates, terms, and conditions. We anticipate that this action will benefit many small entities, including property owners and managers. We emphasize that our proposal as adopted will not impair the authority under state law, of property owners and managers to exclude telecommunications carriers from their

[137] 47 U.S.C. 224.

[138] 47 U.S.C. 251.

[139] Competitive Networks NPRM, 14 FCC Rcd at 12707, paragraph 64.

[140] See Competitive Networks FNPRM, Section V.A., supra.

[141] Competitive Networks NPRM, 14 FCC Rcd at 12707, paragraph 64.

[142] See Competitive Networks First Report and Order, at paragraph 36, and Competitive Networks FNPRM, Section V.A., supra.

[143] See Competitive Networks First Report and Order, at paragraph 33.

[144] See Competitive Networks FNPRM, Section V.B., supra.

[145] See, e.g., AT&T Comments at 26; Qwest Comments at 11; SBC Comments at 7; and Teligent Comments at 17–19.

[146] Competitive Networks NPRM, 14 FCC Rcd at paragraphs 67 and 68. The minimum point of entry is defined as ''either the closest practicable point to where the wiring crosses a property line or the closest practicable point to where the wiring enters a multiunit building or buildings.'' 47 CFR 68.3 (definition of demarcation point).

[147] Competitive Networks First Report and Order, at paragraphs 52–53.

[148] See Competitive Networks First Report and Order, at paragraphs 54–57.

[149] *Id.*, at paragraph 58.

[150] 47 U.S.C. 224.

property.[151] Rather, building owners and managers, and their tenants, will benefit from our proposal because utilities, as defined in section 224(a)(1) of the Act,[152] will no longer have the unfettered ability to exclude telecommunications carriers from their poles, ducts, conduits, and defined rights-of way in MTEs. Telecommunications carriers, including small entities, will benefit from increased access to MTEs. We note that, although it did not file comments on the IRFA, the National League of Cities expressed concern that our proposed implementation of section 224 within buildings may preempt implementation or enforcement of state safety-related codes.[153] As we make clear in the Competitive Networks First Report and Order, ''our actions taken today are not intended to preempt, or impede, in any way the implementation or enforcement of state safety-related codes.'' [154]

64. Fourth, we are amending section 1.4000 of our rules (the ''OTARD rule'')[155] to protect the ability of customers to place antennas used for transmitting and receiving all forms of fixed wireless transmissions. Section 1.4000 currently prohibits any state or local law or regulation, private covenant, contract provision, lease provision, homeowners' association rule, or similar restriction that impairs the installation, maintenance, or use of certain antennas designed to receive video programming services on property within the exclusive use or control of the antenna user where the user has a direct or indirect ownership or leasehold interest in the property.

65. Currently, section 1.4000 prohibits restrictions that impair the installation, maintenance or use of: (1) Any antenna designed to receive direct broadcast satellite service, including direct-to-home satellite services, that is one meter or less in diameter or is located in Alaska; (2) any antenna designed to receive video programming services via multipoint distribution services, including multichannel multipoint distribution services, and local multipoint distribution services, and that is one meter or less in diameter; (3) any antenna designed to receive television broadcast signals; or (4) any mast supporting an antenna receiving any video programming described in the section. For the purposes of section 1.4000, a law, regulation or restriction impairs installation, maintenance or use of an antenna if it unreasonably delays or prevents installation, maintenance or use, unreasonably increases the cost of installation, maintenance or use, or precludes reception of an acceptable quality signal. Section 1.4000 also includes provisions for waiver and declaratory ruling proceedings.

66. There is widespread support in the record for an extension of the OTARD rule to include all fixed wireless services.[156] Moreover, we believe that extending the OTARD rule to include all fixed wireless services is essential to meeting our obligation to promote the deployment of advanced telecommunications capability under Section 706(a) of the 1996 Act.[157] To the extent a restriction unreasonably limits a customer's ability to place antennas to receive communications services, that restriction may impede the development of advanced, competitive services.

67. The *Competitive Networks First Report and Order* underscores the policy rationale for amending the OTARD rule:

> [D]istinguishing in the protection afforded based on the services provided through an antenna produces irrational results. Precisely the same antennas may be used for video services, telecommunications, and internet access. Indeed, sometimes a single company offers different packages of services using the same type of antennas. Under our current rules, a customer ordering a telecommunications/video package would enjoy protection that a customer ordering a telecommunications-only package from the same company using the same antenna would not. Thus, we conclude that the current rules potentially distort markets by creating incentives to include video programming service in many service offerings even if it is not efficient or desired by the consumer.[158]

We do not anticipate that today's rule change will have a significant adverse economic impact on small entities. To the contrary, we expect that small communications carriers that previously were unable to serve customers in MTEs may now be able to do so as a result of our rule change. However, we emphasize that ''the action we take today does not confer a right as against the building owner in restricted or common use areas in commercial or residential buildings, like most rooftops.'' [159] Rather our extension of the OTARD rule to wireless services ''applies only to areas within the exclusive use or control of the antenna user and in which the antenna user has a direct or indirect ownership or leasehold interest.''[160]

68. We also note that any impact on small entities is mitigated by our preservation of the exceptions to the OTARD rule permitting certain restrictions for safety and historic preservation purposes. Restrictions that would otherwise be forbidden are permitted if they are necessary to achieve certain safety or historic preservation purposes, are no more burdensome than necessary to achieve their purpose, and meet certain other conditions set forth in the OTARD rule. Finally, to address any potential concerns regarding transmitting antennas, we have determined that ''[t]o the extent that local governments, associations, and property owners elect to require professional installation for transmitting antennas, the usual prohibition of such requirements under the OTARD rule will not apply.'' [161]

Report to Congress

The Commission will send a copy of the Competitive Networks First Report and Order, including this FRFA, in a report to be sent to Congress pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996, see 5 U.S.C. 801(a)(1)(A). In addition, the Commission will send a copy of the Competitive Networks First Report and Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the Competitive Networks First Report and Order and FRFA (or summaries thereof) will also be published in the **Federal Register**. See 5 U.S.C. 604(b).

Ordering Clauses

69. Pursuant to sections 1, 2(a), 4(j), 4(i), 7, 201, 202, 205, 221, 224, 251, 303, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 152(a), 154(i), 154(j), 157, 201, 202, 205, 221, 224, 251, 303, and 405, that this First Report and Order and Further Notice of Proposed Rulemaking in WT Docket No. 99–217, Fifth Report and Order and Memorandum Opinion and Order in CC Docket No. 96–98, and Fourth Report and Order and Memorandum Opinion and Order in CC Docket No. 88–57 and the amendments to the Commission's rules set forth are ADOPTED.

70. Sections 64.2500, 64.2501, and 64.2502 of the Commission's rules, 47 CFR 64.2500, 64.2501, and 64.2502, set forth in the Rule Changes, *Shall Become*

[151] See Competitive Networks First Report and Order, at paragraph 87.

[152] 47 U.S.C. 224(a)(1).

[153] National League of Cities, et al. Petition for EIS at 21–24.

[154] Competitive Networks First Report and Order, at paragraph 84.

[155] 47 CFR 1.4000.

[156] See e.g., AT&T Comments; PCIA Comments; Fixed Wireless Communications Coalition Comments; and Teligent Comments.

[157] 47 U.S.C. 157 note.

[158] Competitive Networks First Report and Order, at paragraph 98.

[159] *Id.*, at paragraph 124.

[160] *Id.*, at paragraph 100.

[161] *Id.*, at paragraph 119.

Effective March 12, 2001. The rule changes to 47 CFR 1.4000 and the rule changes amending the definition of the term ''demarcation point'' in 47 CFR 68.3 contain an information collection requirement that has not yet been approved by OMB; the FCC will publish a document in the **Federal Register** announcing the effective date of these rule changes.

71. The motions to submit Further Reply Comments filed by Concerned Communities and Organizations and the Wireless Communications Association International *Are Granted.*

72. The Petition for Clarification and Reconsideration of the 1997 Demarcation Point Order filed by Bell Atlantic *Is Granted,* as discussed in section IV.C.

73. The Petition for Clarification and Reconsideration of the 1997 Demarcation Point Order filed by BellSouth *Is Denied,* as discussed in section IV.C.

74. The Petition for Reconsideration of the Local Competition First Report and Order filed by WinStar *Is Granted* to the extent discussed in section IV.D and otherwise *Is Denied.*

75. The Petition for Environmental Impact Statement filed by the National League of Cities, the National Association of Counties, the Michigan Municipal League, and the Texas Coalition of Cities for Utility Issues *Is Denied* as discussed in Section IV.E, except to the extent that the Petition concerns issues raised in the Notice of Inquiry portion of the Competitive Networks NPRM, which will be addressed separately at a later time.

76. The Commission's Consumer Information Bureau, Reference Information Center, *Shall Send* a copy of this First Report and Order and Further Notice of Proposed Rulemaking, Fifth Report and Order and Memorandum Opinion and Order, and Fourth Report and Order and Memorandum Opinion and Order, including the Final Regulatory Flexibility Analysis and the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration in accordance with Sections 603(a) and 604(b) of the Regulatory Flexibility Act, Public Law 96–354, 94 Stat. 1164, 5 U.S.C. 603(a), 604(b).

List of Subjects

47 CFR Part 1

Communications common carriers, Telecommunications, Television.

47 CFR Part 64

Communications common carriers, Telecommunications, Telephone.

47 Part 68

Communications common carriers, Communications equipment, Telecommunications, Telephone.

Federal Communications Commission.

Shirley S. Suggs,

Chief, Publications Group.

Rule Changes

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR parts 1, 64, and 68 as follows:

PART 1—PRACTICE AND PROCEDURES

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

Authority: 47 U.S.C. 151, 154(i), 154(j), 155, 225, 303(r), 309.

2. Revise Subpart S to read as follows:

Subpart S—Preemption of Restrictions That ''Impair'' the Ability to Receive Television Broadcast Signals, Direct Broadcast Satellite Services, or Multichannel Multipoint Distribution Services or the Ability To Receive or Transmit Fixed Wireless Communications Signals

Sec.

1.4000 Restrictions impairing reception of television broadcast signals, direct broadcast satellite services, or multichannel multipoint distribution services and restrictions impairing reception or transmission of fixed wireless communications signals.

§ 1.4000 Restrictions impairing reception of television broadcast signals, direct broadcast satellite services, or multichannel multipoint distribution services and restrictions impairing reception or transmission of fixed wireless communications signals.

(a)(1) Any restriction, including but not limited to any state or local law or regulation, including zoning, land-use, or building regulations, or any private covenant, contract provision, lease provision, homeowners' association rule or similar restriction, on property within the exclusive use or control of the antenna user where the user has a direct or indirect ownership or leasehold interest in the property that impairs the installation, maintenance, or use of:

(i) An antenna that is:

(A) Used to receive direct broadcast satellite service, including direct-to-home satellite service, or to receive or transmit fixed wireless signals via satellite, and

(B) One meter or less in diameter or is located in Alaska;

(ii) An antenna that is:

(A) Used to receive video programming services via multipoint distribution services, including multichannel multipoint distribution services, instructional television fixed services, and local multipoint distribution services, or to receive or transmit fixed wireless signals other than via satellite, and

(B) That is one meter or less in diameter or diagonal measurement;

(iii) An antenna that is used to receive television broadcast signals; or

(iv) A mast supporting an antenna described in paragraphs (a)(1)(i), (a)(1)(ii), or (a)(1)(iii) of this section; is prohibited to the extent it so impairs, subject to paragraph (b) of this section.

(a)(2) For purposes of this section, ''fixed wireless signals'' means any commercial non-broadcast communications signals transmitted via wireless technology to and/or from a fixed customer location. Fixed wireless signals do not include, among other things, AM radio, FM radio, amateur (''HAM'') radio, Citizen's Band (CB) radio, and Digital Audio Radio Service (DARS) signals.

(a)(3) For purposes of this section, a law, regulation, or restriction impairs installation, maintenance, or use of an antenna if it:

(i) Unreasonably delays or prevents installation, maintenance, or use;

(ii) Unreasonably increases the cost of installation, maintenance, or use; or

(iii) Precludes reception or transmission of an acceptable quality signal.

(a)(4) Any fee or cost imposed on a user by a rule, law, regulation or restriction must be reasonable in light of the cost of the equipment or services and the rule, law, regulation or restriction's treatment of comparable devices. No civil, criminal, administrative, or other legal action of any kind shall be taken to enforce any restriction or regulation prohibited by this section except pursuant to paragraph (d) or (e) of this section. In addition, except with respect to restrictions pertaining to safety and historic preservation as described in paragraph (b) of this section, if a proceeding is initiated pursuant to paragraph (d) or (e) of this section, the entity seeking to enforce the antenna restrictions in question must suspend all enforcement efforts pending completion of review. No attorney's fees shall be collected or assessed and no fine or other penalties shall accrue against an antenna user while a proceeding is pending to determine the validity of any restriction. If a ruling is issued adverse to a user, the user shall be granted at least a 21-day grace period

in which to comply with the adverse ruling; and neither a fine nor a penalty may be collected from the user if the user complies with the adverse ruling during this grace period, unless the proponent of the restriction demonstrates, in the same proceeding which resulted in the adverse ruling, that the user's claim in the proceeding was frivolous.

(b) Any restriction otherwise prohibited by paragraph (a) of this section is permitted if:

(1) It is necessary to accomplish a clearly defined, legitimate safety objective that is either stated in the text, preamble, or legislative history of the restriction or described as applying to that restriction in a document that is readily available to antenna users, and would be applied to the extent practicable in a non-discriminatory manner to other appurtenances, devices, or fixtures that are comparable in size and weight and pose a similar or greater safety risk as these antennas and to which local regulation would normally apply; or

(2) It is necessary to preserve a prehistoric or historic district, site, building, structure or object included in, or eligible for inclusion on, the National Register of Historic Places, as set forth in the National Historic Preservation Act of 1966, as amended, 16 U.S.C. 470, and imposes no greater restrictions on antennas covered by this rule than are imposed on the installation, maintenance, or use of other modern appurtenances, devices, or fixtures that are comparable in size, weight, and appearance to these antennas; and

(3) It is no more burdensome to affected antenna users than is necessary to achieve the objectives described in paragraphs (b)(1) or (b)(2) of this section.

(c) In the case of an antenna that is used to transmit fixed wireless signals, the provisions of this section shall apply only if a label is affixed to the antenna that:

(1) Provides adequate notice regarding potential radiofrequency safety hazards, e.g., information regarding the safe minimum separation distance required between users and transceiver antennas; and

(2) References the applicable FCC-adopted limits for radiofrequency exposure specified in § 1.1310 of this chapter.

(d) Local governments or associations may apply to the Commission for a waiver of this section under § 1.3 of this chapter. Waiver requests must comply with the procedures in paragraphs (f) and (h) of this section and will be put on public notice. The Commission may grant a waiver upon a showing by the applicant of local concerns of a highly specialized or unusual nature. No petition for waiver shall be considered unless it specifies the restriction at issue. Waivers granted in accordance with this section shall not apply to restrictions amended or enacted after the waiver is granted. Any responsive pleadings must be served on all parties and filed within 30 days after release of a public notice that such petition has been filed. Any replies must be filed within 15 days thereafter.

(e) Parties may petition the Commission for a declaratory ruling under § 1.2 of this chapter, or a court of competent jurisdiction, to determine whether a particular restriction is permissible or prohibited under this section. Petitions to the Commission must comply with the procedures in paragraphs (f) and (h) of this section and will be put on public notice. Any responsive pleadings in a Commission proceeding must be served on all parties and filed within 30 days after release of a public notice that such petition has been filed. Any replies in a Commission proceeding must be served on all parties and filed within 15 days thereafter.

(f) Copies of petitions for declaratory rulings and waivers must be served on interested parties, including parties against whom the petitioner seeks to enforce the restriction or parties whose restrictions the petitioner seeks to prohibit. A certificate of service stating on whom the petition was served must be filed with the petition. In addition, in a Commission proceeding brought by an association or a local government, constructive notice of the proceeding must be given to members of the association or to the citizens under the local government's jurisdiction. In a court proceeding brought by an association, an association must give constructive notice of the proceeding to its members. Where constructive notice is required, the petitioner or plaintiff must file with the Commission or the court overseeing the proceeding a copy of the constructive notice with a statement explaining where the notice was placed and why such placement was reasonable.

(g) In any proceeding regarding the scope or interpretation of any provision of this section, the burden of demonstrating that a particular governmental or nongovernmental restriction complies with this section and does not impair the installation, maintenance, or use of devices used for over-the-air reception of video programming services or devices used to receive or transmit fixed wireless signals shall be on the party that seeks to impose or maintain the restriction.

(h) All allegations of fact contained in petitions and related pleadings before the Commission must be supported by affidavit of a person or persons with actual knowledge thereof. An original and two copies of all petitions and pleadings should be addressed to the Secretary, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. Copies of the petitions and related pleadings will be available for public inspection in the Reference Information Center, Consumer Information Bureau, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. Copies will be available for purchase from the Commission's contract copy center, and Commission decisions will be available on the Internet.

PART 64—MISCELLANEOUS RULES RELATING TO COMMON CARRIERS

1. The authority citation for part 64 continues to read:

Authority: 47 U.S.C. 151, 154, 201, 202, 205, 218–220, and 332 unless otherwise noted. Interpret or apply sections 201, 218, 225, 226, 227, 229, 332, 48 Stat. 1070, as amended. 47 U.S.C. 201–204, 208, 225, 226, 227, 229, 332, 501 and 503 unless otherwise noted.

2. Add Subpart Z to read as follows:

Subpart Z—Prohibition on Exclusive Telecommunications Contracts

Sec.

64.2500 Prohibited agreements.
64.2501 Scope of limitation.
64.2502 Effect of State law or regulation.

§ 64.2500 Prohibited agreements.

No common carrier shall enter into any contract, written or oral, that would in any way restrict the right of any commercial multiunit premises owner, or any agent or representative thereof, to permit any other common carrier to access and serve commercial tenants on that premises.

§ 64.2501 Scope of limitation.

For the purposes of this subpart, a multiunit premises is any contiguous area under common ownership or control that contains two or more distinct units. A commercial multiunit premises is any multiunit premises that is predominantly used for non-residential purposes, including for-profit, non-profit, and governmental uses. Nothing in this subpart shall be construed to forbid a common carrier from entering into an exclusive contract to serve only residential customers on any premises.

§ 64.2502 Effect of state law or regulation.

This subpart shall not preempt any state law or state regulation that requires a governmental entity to enter into a contract or understanding with a common carrier which would restrict such governmental entity's right to obtain telecommunications service from another common carrier.

PART 68—CONNECTION OF TERMINAL EQUIPMENT TO THE TELEPHONE NETWORK

1. The authority citation for part 68 continues to read:

Authority: Secs. 4, 5, 303, 48 Stat., as amended, 1066, 1068, 1082; (47 U.S.C. 154, 155, 303).

2. Section 68.3 is amended by revising the definition of ''demarcation point'' to read as follows:

§ 68.3 Definitions.

* * * * *

Demarcation point: The point of demarcation and/or interconnection between telephone company communications facilities and terminal equipment, protective apparatus or wiring at a subscriber's premises. Carrier-installed facilities at, or constituting, the demarcation point shall consist of wire or a jack conforming to subpart F of part 68 of the Commission's rules. ''Premises'' as used herein generally means a dwelling unit, other building or a legal unit of real property such as a lot on which a dwelling unit is located, as determined by the telephone company's reasonable and nondiscriminatory standard operating practices. The ''minimum point of entry'' as used herein shall be either the closest practicable point to where the wiring crosses a property line or the closest practicable point to where the wiring enters a multiunit building or buildings. The telephone company's reasonable and nondiscriminatory standard operating practices shall determine which shall apply. The telephone company is not precluded from establishing reasonable classifications of multiunit premises for purposes of determining which shall apply. Multiunit premises include, but are not limited to, residential, commercial, shopping center and campus situations.

(a) *Single unit installations.* For single unit installations existing as of August 13, 1990, and installations installed after that date the demarcation point shall be a point within 30 cm (12 in) of the protector or, where there is no protector, within 30 cm (12 in) of where the telephone wire enters the customer's premises, or as close thereto as practicable.

(b) *Multiunit installations.* (1) In multiunit premises existing as of August 13, 1990, the demarcation point shall be determined in accordance with the local carrier's reasonable and non-discriminatory standard operating practices. Provided, however, that where there are multiple demarcation points within the multiunit premises, a demarcation point for a customer shall not be further inside the customer's premises than a point twelve inches from where the wiring enters the customer's premises, or as close thereto as practicable.

(2) In multiunit premises in which wiring is installed, including major additions or rearrangements of wiring existing prior to that date, the telephone company may place the demarcation point at the minimum point of entry (MPOE). If the telephone company does not elect to establish a practice of placing the demarcation point at the minimum point of entry, the multiunit premises owner shall determine the location of the demarcation point or points. The multiunit premises owner shall determine whether there shall be a single demarcation point location for all customers or separate such locations for each customer. Provided, however, that where there are multiple demarcation points within the multiunit premises, a demarcation point for a customer shall not be further inside the customer's premises than a point 30 cm (12 in) from where the wiring enters the customer's premises, or as close thereto as practicable. At the time of installation, the telephone company shall fully inform the premises owner of its options and rights regarding the placement of the demarcation point or points and shall not attempt to unduly influence that decision for the purpose of obstructing competitive entry.

(3) In any multiunit premises where the demarcation point is not already at the MPOE, the telephone company must comply with a request from the premises owner to relocate the demarcation point to the MPOE. The telephone company must negotiate terms in good faith and complete the negotiations within forty-five days from said request. Premises owners may file complaints with the Commission for resolution of allegations of bad faith bargaining by telephone companies. See 47 U.S.C. 208; 47 CFR 1.720 through 1.736 (1999) of this chapter.

(4) The telephone company shall make available information on the location of the demarcation point within ten business days of a request from the premises owner. If the telephone company does not provide the information within that time, the premises owner may presume the demarcation point to be at the MPOE. Notwithstanding the provisions of 47 CFR 68.110(c), telephone companies must make this information freely available to the requesting premises owner.

(5) In multiunit premises with more than one customer, the premises owner may adopt a policy restricting a customer's access to wiring on the premises to only that wiring located in the customer's individual unit that serves only that particular customer.

* * * * *

[FR Doc. 01–843 Filed 1–10–01; 8:45 am]

BILLING CODE 6712–01–U

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 51

[CC Docket Nos. 98–147, 98–11, 98–26, 98–32, 98–15, 98–78, 98–91; FCC 00–293]

Deployment of Wireline Services Offering Advanced Telecommunications Capability

AGENCY: Federal Communications Commission (FCC).

ACTION: Final Rule; denial of reconsideration.

SUMMARY: This document affirms on reconsideration the Commission's determination that section 706(a) of the Telecommunications Act of 1996 (1996 Act) does not constitute an independent grant of forbearance authority. This documents also affirms on reconsideration the requirement that incumbent local exchange carriers (LECs) must provide unbundled loops conditioned to carry advanced services, even if the incumbent is not itself providing such services.

FOR FURTHER INFORMATION CONTACT: William Kehoe, Special Counsel, Common Carrier Bureau, Policy and Program Planning Division, 202–418–1580. Further information also may be obtained by calling the Common Carrier Bureau's TTY number: 202–418–0484.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Order on Reconsideration in CC Docket No. 98–147, FCC 00–293, adopted on August 3, 2000, and released August 4, 2000. The complete text of this Order on Reconsideration is available for inspection and copying during normal business hours in the FCC Reference Information Center, Courtyard Level, 445 Twelfth Street, SW. Washington,

DC, and also may be purchased from the Commission's copy contractor, International Transcription Services (ITS), CY–B400, 445 Twelfth Street, SW., Washington, DC.

1. In the Advanced Services Order, 63 FR 45140, August 24, 1998, the Commission addressed, among other matters, petitions in which several BOCs, including Bell Atlantic and SBC, had requested that the Commission forbear from applying the provisions of sections 251(c) and 271 to their advanced services. In rejecting those requests, the Commission explained in detail why, in light of the statutory language, the framework of the 1996 Act, its legislative history, and Congress' policy objectives, the most logical statutory interpretation is that section 706(a) does not constitute an independent grant of authority. The Commission therefore determined that section 706(a) does not constitute an independent grant of forbearance authority. In petitions for reconsideration of the Advanced Services Order, Bell Atlantic and SBC challenged that determination. In the Order on Reconsideration, the Commission affirmed that section 706(a) does not constitute an independent grant of forbearance authority.

2. In the Advanced Services Order, the Commission concluded that the rules adopted in the Local Competition First Report and Order required that, to the extent technically feasible, an incumbent LEC must provide to competing carriers unbundled loops conditioned to carry advanced services, even if the incumbent is not itself providing such services. Bell Atlantic and SBC requested reconsideration of this conclusion. In the Order on Reconsideration, the Commission denied that request based on the treatment of loop conditioning in its UNE Remand Order.

Paperwork Reduction Act of 1995 Analysis

3. The actions contained in this Order on Reconsideration affirmed prior Commission actions and thus do not impose new or modified reporting requirements on the public.

Regulatory Flexibility Analysis (RFA)

4. The Order on Reconsideration affirmed prior Commission actions and thus does not change the Commission's regulatory flexibility analysis.

Procedural Matters

5. Pursuant to sections 1–4, 10, 201, 202, 251–254, 271, and 303(r) of the Communications Act of 1934, as amended, 47 U.S.C. 151–154, 160, 201, 202, 251–254, 271, and 303(r), that the Petitions for Reconsideration filed September 8, 1998, by Bell Atlantic and SBC *Are Denied.*

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

[FR Doc. 01–670 Filed 1–10–01; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 01–02, MM Docket No. 00–178, RM–9914]

Digital Television Broadcast Service; Charlotte, NC

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission, at the request of Charlotte-Mecklenburg Public Broadcasting Authority, licensee of noncommercial educational station WTVI–TV, NTSC channel * 42, substitutes DTV channel * 11 for station WTVI–TV's assigned DTV channel * 24 at Charlotte, North Carolina. *See* 65 FR 59388, October 5, 2000. DTV channel * 11 can be allotted to Charlotte in compliance with the principle community coverage requirements of Section 73.625(a) at reference coordinates (35–17–14 N. and 80–41–45 W.) with a power of 2.0, HAAT of 387 meters and with a DTV service population of 1747 thousand. With is action, this proceeding is terminated.

DATES: Effective February 20, 2001.

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Mass Media Bureau, (202) 418–1600.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order, MM Docket No. 00–178, adopted January 2, 2001, and released January 5, 2001. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center 445 12th Street, SW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Services, Inc., (202) 857–3800, 1231 20th Street, NW., Washington, DC 20036.

List of Subjects in 47 CFR Part 73

Television, Digital television broadcasting.

Part 73 of Title 47 of the Code of Federal Regulations is amended as follows:

PART 73—[AMENDED]

1. The authority citation for Part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, 336.

§ 73.622 [Amended]

2. Section 73.622(b), the Table of Digital Television Allotments under North Carolina, is amended by removing DTV channel * 24 and adding DTV channel * 11 at Charlotte.

Federal Communications Commission.

Barbara A. Kreisman,

Chief, Video Services Division, Mass Media Bureau.

[FR Doc. 01–677 Filed 1–10–01; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 229

[Docket No. 001011283-0371-02; I.D. 082200C]

RIN 0648-AO30

Taking of Marine Mammals Incidental to Commercial Fishing Operations; Harbor Porpoise Take Reduction Plan Regulations; Change to the List of Exempted Waters

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

ACTION: Final rule.

SUMMARY: NMFS amends the Harbor Porpoise Take Reduction Plan (HPTRP) to redefine Delaware Bay in the list of exempted waters to include waters landward of the 72 COLREGS line (International Regulations for Preventing Collisions at Sea, 1972). Members of the Mid-Atlantic Harbor Porpoise Take Reduction Team (MATRT) recommended by consensus that NMFS redefine the list of exempted waters because harbor porpoise stranding and observer data did not justify subjecting fishers in Delaware Bay to the HPTRP gear restrictions. The intent of this final rule is to exempt fishers operating in Delaware Bay from the HPTRP regulations as it is redefined under this rule.

DATES: Effective January 11, 2001.

FOR FURTHER INFORMATION CONTACT: Gregg Lamontagne, NMFS, Northeast

Region, 978-281-9291; Kim Thounhurst, NMFS Northeast Region, 978-281-9138; Diane Borggaard, NMFS, Southeast Region, 727-570-5312; or Emily Hanson, NMFS Office of Protected Resources, 301-713-2322, ext. 101.

SUPPLEMENTARY INFORMATION: Section 118 of the Marine Mammal Protection Act (MMPA) authorizes NMFS to issue regulations to implement a marine mammal take reduction plan or amendments to a marine mammal take reduction plan that, among other things, may restrict fishing by time or area. On December 2, 1998, NMFS published a final rule (63 FR 66464) implementing the HPTRP. Among other measures, the final rule identified those waters that are exempt from the HPTRP (50 CFR 229.34).

The MATRT met on January 13 and 14, 2000, in Alexandria, VA. The MATRT recommended by consensus that the line defining the exempted waters of Delaware Bay be moved seaward from 39° 16.70'N 75° 14.60'W TO 39° 11.25'N 75° 23.90'W (i.e., southern point of Nantuxent Cove, NJ to the southern end of Kelly Island, Port Mahon, DE) and be redefined as a line from the Cape May Canal to the Lewes Ferry Terminal. The MATRT concluded that there was no compelling reason for maintaining the existing position of the line in Delaware Bay, compared to other large bays in the Mid-Atlantic region (e.g., Chesapeake Bay, Long Island Sound), which typically establish the exempted waters as landward of the mouth of an inlet or the 72 COLREGS line. The MATRT believed that the existing line imposed unnecessary requirements on the Delaware Bay fishing community because harbor porpoise stranding data and observer data did not justify imposing HPTRP gear restrictions on fishers in Delaware Bay.

NMFS published a proposed rule on October 27, 2000 (65 FR 64415), to redefine exempted waters for Delaware Bay to include all marine and tidal waters landward of the 72 COLREGS demarcation line, as depicted or noted on nautical charts published by NOAA (Coast Charts 1:80,000 scale), and as described in 33 CFR part 80. Using the COLREGS line is a slight deviation from the MATRT's consensus recommendation. The 72 COLREGS line was selected instead of the line recommended by the MATRT because the 72 COLREGS line is a well known and widely published line of demarcation. The actual difference between the COLREGS line and the MATRT recommended line is a seaward shift of approximately 1 nautical mile.

In the proposed rule, NMFS requested comments on the MATRT's consensus recommendation to change the definition of small mesh gillnet to mean a gillnet constructed with a mesh size of greater than 5.5 inches (13.97 cm) but less than 7 inches (17.78 cm). As currently defined in 50 CFR 229.2, small mesh gillnet means a gillnet constructed with a mesh size of greater than 5 inches (12.7 cm) to less than 7 inches (17.78 cm). NMFS did not propose implementing the MATRT's recommendation to change the definition of small mesh gillnet because of sea sampling observer data from the Mid-Atlantic in 1999 and 2000, which reported four takes in 4.9-5.0 inch mesh size gillnet (reported by a vessel captain) with shad as the primary species sought. NMFS was concerned about implementing the MATRT's recommendation, which would relax the requirements of the HPTRP, while takes continued to occur in similar mesh sizes.

Comments and Responses to the Notice of Proposed Change to the HPTRP

Five comment letters were received in response to the October 27, 2000, proposed rule. Comment letters were received from state agencies and commercial fishing organizations. The comments are summarized here followed by NMFS responses thereto.

Comments on the Proposed Change to the List of Exempted Waters

All five commenters supported the proposed change to the line delineating exempted waters for Delaware Bay.

Response

For the reasons discussed in the preamble to the proposed rule, NMFS' is publishing this final rule to implement the change proposed on October 27, 2000 (65 FR 64415).

Comments on the MATRT's Recommendation to Change the Definition of Small Mesh Gillnet

All five commenters supported the MATRT's recommendation to redefine small mesh gillnet, primarily because of the impact the existing regulations have on the shad fishery. According to the commenters, fishers targeting shad have two options under the existing regulations, both of which could have negative impacts on the shad population, the fishers, and harbor porpoise. One, fishers may opt to use mesh sizes of 5 inches (12.7 cm) and less to avoid the requirements of the HPTRP. The use of smaller mesh leads to increased catches of smaller shad, both bucks and young females, which have a low market value. Additionally, the young females caught may not have spawned. This would cause both a negative economic impact on the fishers and a negative biological impact on shad populations. Also, fishers may opt to fish with mesh sizes of greater than 5 inches (12.7 cm) and use the twine size required by the HPTRP, which is heavier than twine size traditionally used in the shad fishery. The heavy twine size does not effectively catch shad, causing a negative economic impact on the fishers. Both options could result in increased fishing effort as more net is set to mitigate for lost catch or catch with a lower market value, which could increase the likelihood of interactions with marine mammals.

Commenters also noted that the shad fishery has exhibited low levels of harbor porpoise interaction and that the Atlantic States Marine Fisheries Commission's (ASMFC) Interstate Fishery Management Plan for shad encourages the use of mesh with a size larger than 5 inches (12.7 cm) because it increases the harvest of larger, more valuable female shad that have already spawned. Commenters stated that the ASMFC will be phasing out the ocean intercept shad fishery by 2005, however it is still economically important for fishers to be able to fish for shad until the fishery is closed.

One commenter noted that the MATRT's proposal would exempt most of Delaware's ocean gill netting operations from the HPTRP. Another commenter noted that the MATRT's recommendation would decrease the bycatch mortality of striped bass during their spring migration along the east coast. If the current definition of small mesh gillnet remains, fishers in New Jersey who want to use mesh with a size of 5.5 inch (13.97 cm) would be required to use heavier twine size than is traditionally used, which would increase striped bass mortality.

Response

NMFS is not implementing the MATRT's mesh size proposal at this time, due to takes of harbor porpoise in mesh sizes of 4.9-5.0 inches in 2000. The issue of redefining small mesh gillnet and reducing takes in gillnet gear with mesh sizes of 5 inches (12.7 cm) and less was addressed by the MATRT at its annual meeting November 28-30, 2000. The MATRT was not able to develop a consensus recommendation for NMFS to redefine small mesh gillnet while also addressing the takes observed in 1999 and 2000.

NMFS plans to continue observing the mid-Atlantic coastal gillnet fisheries,

including vessels using small mesh gillnet, and expanding observer coverage to vessels using gillnet mesh sizes of 5.0 inches (12.7 cm) or smaller to both monitor existing levels of harbor porpoise take and to learn what gear characteristics or operational characteristics take harbor porpoise. If the MATRT or fishers identify gear characteristics or operational characteristics that allow NMFS to relieve restrictions while still reducing the take of harbor porpoise incidental to commercial fishing operations, NMFS will consider implementing appropriate changes to the HPTRP. Additionally, NMFS will consult with ASMFC to determine if other options exist that NMFS has not yet considered.

Classification

NMFS prepared an Environmental Assessment (EA) of the final rule (63 FR 66464, Dec. 2, 1998) to implement the HPTRP. This final rule amends the HPTRP. NMFS prepared an EA for this action and determined that amending the HPTRP as described in this final rule will not have a significant impact on the quality of the human environment.

The Chief Counsel for Regulation for the Department of Commerce certified to the Chief Counsel for Advocacy for the Small Business Administration when this rule was proposed that it would not have a significant adverse economic impact on a substantial number of small entities. While comments were received regarding the economic impact on small entities of a MATRT recommendation which NMFS did not propose to implement in the proposal, no comments regarding the economic impact of NMFS' proposal were received. Accordingly, the basis for the certification has not changed and NMFS has not prepared a Regulatory Flexibility Analysis.

This final rule does not contain any collection of information requirement subject to the Paperwork Reduction Act.

A section 7 Endangered Species Act (ESA) consultation on the HPTRP was conducted on November 12, 1998. That consultation concluded that measures specific to the HPTRP are not likely to adversely affect any ESA listed species under NMFS jurisdiction. Due to environmental conditions, turtles do not occur in Delaware Bay during the same time that the HPTRP restrictions are in place. Therefore, lifting the restrictions in Delaware Bay is not likely to impact turtles, and therefore no further section 7 consultation is required. This final rule falls within the scope of the section 7 consultation on the HPTRP and is not likely to adversely affect endangered or threatened species.

The changes in the HPTRP made by this final rule are not expected to have adverse impacts on marine mammals.

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

This final rule does not change the determination that the HPTRP will be implemented in a manner that is consistent to the maximum extent practicable with the approved coastal management programs of the Atlantic states.

This final rule is promulgated in compliance with all procedural requirements established by the Administrative Procedure Act.

List of Subjects in 50 CFR Part 229

Administrative practice and procedure, Confidential business information, Fisheries, Marine mammals, Reporting and recordkeeping requirements.

Dated: January 4, 2000.

Penelope D. Dalton,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 229 is amended as follows:

PART 229—AUTHORIZATION FOR COMMERCIAL FISHERIES UNDER THE MARINE MAMMAL PROTECTION ACT OF 1972

1. The authority citation for part 229 continues to read as follows:

Authority: 16 U.S.C. 1361 *et seq.*

2. In § 229.34, paragraph (a)(2) is revised to read as follows:

§ 229.34 Harbor Porpoise Take Reduction Plan - Mid-Atlantic.

(a) * * *

(2) Exempted waters. All waters landward of the first bridge over any embayment, harbor, or inlet will be exempted. The regulations in this section do not apply to waters landward of the following lines:

New York

40° 45.70' N 72° 45.15' W TO 40° 45.72' N 72° 45.30' W (Moriches Bay Inlet)

40° 37.32' N 73° 18.40' W TO 40° 38.00' N 73° 18.56' W (Fire Island Inlet)

40° 34.40' N 73° 34.55' W TO 40° 35.08' N 73° 35.22' W (Jones Inlet)

New Jersey/Delaware

39° 45.90' N 74° 05.90' W TO 39° 45.15' N 74° 06.20' W (Barnegat Inlet)

39° 30.70' N 74° 16.70' W TO 39° 26.30' N 74° 19.75' W (Beach Haven to Brigantine Inlet)

38° 56.20' N 74° 51.70' W TO 38° 56.20' N 74° 51.90' W (Cape May Inlet)

All marine and tidal waters landward of the 72 COLREGS demarcation line (International Regulations for Preventing Collisions at Sea, 1972), as depicted or noted on nautical charts published by NOAA (Coast Charts 1:80,000 scale), and as described in 33 CFR part 80. (Delaware Bay)

Maryland/Virginia

38° 19.48' N 75° 05.10' W TO 38° 19.35' N 75° 05.25' W (Ocean City Inlet)

37° 52.' N 75° 24.30' W TO 37° 11.90' N 75° 48.30' W (Chincoteague to Ship Shoal Inlet)

37° 11.10' N 75° 49.30' W TO 37° 10.65' N 75° 49.60' W (Little Inlet)

37° 07.00' N 75° 53.75' W TO 37° 05.30' N 75° 56.' W (Smith Island Inlet)

North Carolina

All marine and tidal waters landward of the 72 COLREGS demarcation line (International Regulations for Preventing Collisions at Sea, 1972), as depicted or noted on nautical charts published by NOAA (Coast Charts 1:80,000 scale), and as described in 33 CFR part 80.

* * * * *

[FR Doc. 01–913 Filed 1–10–01; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Parts 600 and 660

[Docket No.; I.D. 121500E]

RIN 0648-AN82

Magnuson-Stevens Act Provisions; Fisheries off West Coast States and in the Western Pacific; Pacific Coast Groundfish Fishery; Annual Specifications and Management Measures

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

ACTION: 2001 groundfish fishery specifications and management measures; announcement of the overfished status of darkblotched and widow rockfish; announcement of exempted fishing permits; request for comments.

SUMMARY: NMFS announces the 2001 fishery specifications and management

measures for groundfish taken in the U.S. exclusive economic zone (EEZ) and state waters off the coasts of Washington, Oregon, and California. The specifications include the levels of the acceptable biological catch (ABC) and optimum yields (OYs). The commercial OYs (the OYs reduced by expected discard and by amounts expected to be taken in tribal, recreational, and compensation fisheries) are allocated between the limited entry and open access fisheries. The management measures for 2001 are designed to keep landings within the OYs for those species for which there are OYs and to achieve the goals and objectives of the Pacific Coast Groundfish Fishery Management Plan (FMP) and associated rebuilding plans for overfished stocks, consistent with the requirements of the Magnuson Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) and the guidelines based on the National Standards in the Magnuson-Stevens Act published in the **Federal Register** on May 1, 1998. These management measures are intended to prevent overfishing and to rebuild Pacific Coast groundfish stocks. These measures are also intended to achieve as much harvest of healthier stocks as possible given the conservation requirements of the Magnuson-Stevens Act.

DATES: Effective 0001 hours local time (l.t.) January 5, 2001, until the 2002 annual specifications and management measures are effective, unless modified, superseded, or rescinded. The 2002 annual specifications and management measures will be published in the **Federal Register**. Comments must be received no later than 5:00 p.m, l.t., on February 12, 2001.

ADDRESSES: Written comments on these actions must be mailed to Donna Darm, Acting Administrator, Northwest Region (Regional Administrator), NMFS, 7600 Sand Point Way N.E., BIN C15700, Bldg. 1, Seattle, WA 98115-0070, or faxed to 206-526-6736; or Rebecca Lent, Administrator, Southwest Region, NMFS, 501 West Ocean Blvd., Suite 4200, Long Beach, CA 90802-4213, or faxed to 562-980-4047. Comments will not be accepted if submitted via e-mail or Internet. Information relevant to these specifications and management measures, which includes an environmental assessment/regulatory impact review (EA/RIR) and the stock assessment and fishery evaluation (SAFE) report, is available for public review during business hours at the offices of the NMFS Northwest Regional Administrator and the NMFS Southwest Regional Administrator, or may be obtained from the Pacific Fishery Management Council (Council), at 2130 SW Fifth Avenue, Suite 224, Portland, OR 97201, phone: 503-326-6352. Additional reports referred to in this document may also be obtained from the Council.

Send comments regarding the reporting burden estimate or any other aspect of the collection-of-information requirements in this final rule, including suggestions for reducing the burden, to one of the NMFS addresses and to the Office of Management and Budget (OMB), Washington, D.C. 20503 (ATTN: NOAA Desk Officer). Send comments regarding any ambiguity or unnecessary complexity arising from the language used in this rule to Donna Darm or Rebecca Lent.

FOR FURTHER INFORMATION CONTACT: Yvonne deReynier or Becky Renko (Northwest Region, NMFS), phone: 206-526-6140; fax: 206-526-6736 and; e-mail: *yvonne.dereynier@noaa.gov*, *becky.renko@noaa.gov*or Svein Fougner (Southwest Region, NMFS) phone: 562-980-4000; fax: 562-980-4047 and; e-mail: *svein.fougner@noaa.gov*.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** rule also is accessible via the Internet at the Office of the Federal Register's website at http://www.access.gpo.gov/su--docs/aces/aces140.html. Background information and documents are available at the NMFS Northwest Region website at *http://www.nwr.noaa.gov/1sustfsh/gdfsh01.htm*and at the Council's website at *http://www.pcouncil.org*.

Background

The FMP requires that fishery specifications for groundfish be evaluated and revised, as necessary, each calendar year, that OYs be specified for species or species groups in need of additional protection, and that management measures designed to achieve the OYs be published in the **Federal Register** and made effective by January 1, the beginning of the fishing year. The Magnuson-Stevens Act and the FMP require that NMFS implement actions to prevent overfishing and to rebuild overfished stocks. This action announces and makes effective the final 2001 fishery specifications and the management measures that are designed to rebuild overfished stocks through constraining direct and incidental mortality, to prevent overfishing, and to achieve as much of the OYs as practicable for healthier groundfish stocks managed under the FMP. These final specifications and management measures were considered by the Council at two meetings and were recommended to NMFS by the Council at its November 2000 meeting in Vancouver, WA.

I. Final Specifications

The fishery specifications include ABCs, the designation of OYs, which may be represented by harvest guidelines (HGs) or quotas for species that need individual management, and the allocation of the commercial OYs between the open access and limited entry segments of the fishery. These specifications include fish caught in state ocean waters (0-3 nautical miles (nm) offshore) as well as fish caught in the EEZ (3-200 nm offshore). The OYs and ABCs recommended by the Council and announced in this document are consistent with the Magnuson-Stevens Act, the groundfish FMP, the rebuilding plans initially approved by NMFS in 2000 (lingcod, bocaccio, and Pacific ocean perch (POP)), and the rebuilding plans (canary rockfish and cowcod) adopted by the Council at its November 2000 meeting. In a separate **Federal Register** document, NMFS will announce the availability of canary rockfish and cowcod rebuilding plans for public review.

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Table 1a. 2001 Specifications of Acceptable Biological Catch (ABC), Optimum Yields (Oys), OYs) and Limited Entry and Open Access Allocations, by International North Pacific Fisheries Commission (INPFC) Areas (weights in metric tons).

Species	ACCEPTABLE BIOLOGICAL CATCH (ABC)						OY (Total catch)	Commercial OY (Total Catch)	Allocations total catch			
	Vancouver a/	Columbia	Eureka	Monterey	Conception	Total Catch			Limited Entry		Open Access	
									Mt	%	Mt	%
ROUNDFISH												
Lingcod b/	610		509			1,119	611	251	203	81	48	19.0
Pacific Cod	3,200		c/			3,200	na	3,200	--	--	--	--
Pacific Whiting d/	190,400					190,400	190,400	162,900	--	--	--	--
Sablefish e/ (north of 36°)	7,661				--	7,661	6,895	6,181	5,600	90.6	581	9.4
Sablefish f/ (south of 36°)	--				425	425	212	212	--	--	--	--
FLATFISH												
Dover sole g/	7,151				1,053	8,204	7,677	7,610	--	--	--	--
English sole	2,000		1,100			3,100	na	-	--	--	--	--
Petrale sole h/	1,262		500	800	200	2,762	na	-	--	--	--	--
Arrowtooth flounder	5,800					5,800	na	-	--	--	--	--
Other flatfish	700	3,000	1,700	1,800	500	7,700	na	-	--	--	--	-

Species	ACCEPTABLE BIOLOGICAL CATCH (ABC)						OY (Total catch)	Commercial OY (Total Catch	Allocations total catch			
	Vancouver	Columbia	Eureka	Monterey	Conception	Total Catch			Limited Entry		Open Access	
									Mt	%	Mt	%
ROCKFISH:												
Pacific Ocean Perch i/	1,541			--		1,541	303	303	--	--	--	--
Shortbelly j/	13,900					13,900	13,900	13,900	--	--	--	--
Widow k/	3,727					3,727	2,300	2,260	2,192	97.0	68	3.0
Canary l/	228					228	93	44	39	87.7	5	12.3
Chilipepper m/	c/			2,700		2,700	2,000	1,985	1,106	55.7	879	44.3
Bocaccio n/	c/			122		122	100	52	29	55.7	23	44.3
Splitnose o/	c/			615		615	461	461	--	--	--	--
Yellowtail p/	3,146			c/		3,146	3,146	3,086	2,830	91.7	256	8.3
Shortspine thornyhead north of 36° q/r/	757				--	757	689	685	683	99.7	2	0.27
south of 36° s/	--				123	123	62	62	62	99.7	0	0.27
Longspine thornyhead north of 36° q/t/	2,461				--	2,461	2,461	2,453	--	--	--	--
south of 36° u/	--				390	390	195	195	--	--	--	--
Cowcod v/	c/			19		19	2.4	0				
	c/				2.4	2.4	2.4	0				
Darkblotched w/	302-349					302-349	130	130	127	97.7	3	2.3

Species	ACCEPTABLE BIOLOGICAL CATCH (ABC)						OY (Total catch)	Commercial OY (Total Catch	Allocations total catch			
	Vancouver	Columbia	Eureka	Monterey	Conception	Total Catch			Limited Entry		Open Access	
									Mt	%	Mt	%
Minor Rockfish North x/	4,823			--		4,823	3,137	2,492	2,254	90.4	238	9.6
Minor Rockfish South y/	--			3,556		3,556	2,040	1,090	597	55.7	493	44.3
Remaining rockfish	2,755			854		--	--	--	--	--	--	--
bank z/	c/			350		350	--	--	--	--	--	--
black aa/	1,115					1,115	--	--	--	--	--	--
blackgill bb/	c/			343			--	--	--	--	--	--
bocaccio - north	318					318	--	--	--	--	--	--
chilipepper-north	32					32	--	--	--	--	--	--
redstripe	576			c/		576	--	--	--	--	--	--
sharpchin	307			45		352	--	--	--	--	--	--
silvergrey	38			c/		38	--	--	--	--	--	--
splitnose	242			c/		242	--	--	--	--	--	--
yelloweye	29			c/		29	--	--	--	--	--	--
yellowmouth	99			c/		99	--	--	--	--	--	--
yellowtail-south				116		116	--	--	--	--	--	--
Other rockfish cc/	2,068			2,702		--	-	--	--	--	--	--
OTHER FISH dd/	2,500	7,000	1,200	2,000	2,000	14,700	na	-	--	--	--	-

Table 1b. OYs for minor rockfish by depth sub-groups (weights in metric tons).

Species	Total Catch ABC	OY (Total Catch)			Allocations (total catch)			
					Limited Entry		Open Access	
		Total Catch OY	Recreational Estimate	Commercial OY for minor rockfish and for depth sub-groups	Mt	Percent	Mt	Percent
Minor Rockfish North x/	4,823	3,137	645	2,492	2,254	90.4	238	9.6
Nearshore		987	575	412	222	na	190	na
Shelf		990	70	920	880	na	40	na
Slope		1,160		1,160	1,152	na	8	na
Minor Rockfish South y/	3,556	2,040	950	1,090	597	55.7	493	44.3
Nearshore		662	550	112	34	na	78	na
Shelf		739	400	339	129	na	210	na
Slope		639		639	434	na	195	na

a/ABC applies to the U.S. portion of the Vancouver area, except as noted under individual species.

b/Lingcod was designated as overfished in 1999 when the biomass was believed to be at 10 percent of the unfished biomass. A coastwide assessment was conducted in 2000 and confirmed that the stock is overfished coastwide. Separate ABCs were calculated for the northern (Vancouver-Columbia) and southern (Eureka-Monterey-Conception) areas based on F45% Fmsy proxy. The stock assessment included parts of Canadian waters; however, the U.S. portion of the ABC for the Vancouver area was set at 44 percent of the total for that area. The total catch OY of 611 mt is the sum of the yield for the northern (307 mt) and the southern (304 mt) assessments where a constant exploitation rate that results in a 60 percent probability of rebuilding the stock to Fmsy within 9 years was used. The total catch OY is reduced by 360 mt for the amount that is estimated to be taken by the recreational fishery, resulting in a commercial OY of 251 mt. Tribal vessels land a small amount of lingcod, but do not have a specific allocation at this time. No discards are assumed.

c/"Other species", these are neither common nor important to the commercial and recreational fisheries in the areas footnoted. Accordingly, Pacific cod is included in the non-commercial OY of "other fish" and Rockfish species are included are included in either the "other rockfish" or "remaining rockfish" for the areas footnoted only.

d/Whiting is believed to be at less than 40 percent of its unfished biomass. The 1998 assessment was updated for 2000 using limited new data. The U.S.-Canada ABC (266,000 mt) is based on the updated assessment with the

application of an Fmsy proxy of F40%. Because the biomass is estimated to be within the precautionary zone, the 40-10 default harvest policy was applied reducing the coastwide ABC to 238,000 mt. The whiting U.S. ABC is 80 percent (190,400 mt) of the 238,000 mt. The U.S. total catch OY was then set equal to the U.S. ABC. The commercial OY for whiting is 162,900 mt (the 190,400 mt OY minus the 27,500 mt tribal allocation), and is allocated 42 percent to the shore-based sector, 24 percent to the mothership sector, and 34 percent to the catcher-processor sector. Discards of whiting are estimated from observer data and counted towards the OY inseason.

e/Sablefish north of 36° N. lat. is believed to be at 37 percent of its unfished biomass. The 7,661 ABC for the area north of 36° N. lat. is based on a F45% Fmsy proxy. The total catch OY (6,895 mt) is based on the application of the 40-10 harvest rate policy because the biomass is estimated to be in the precautionary zone. The total catch OY is reduced by 690 mt for the tribal set aside and by 24 mt for the compensation to vessels that conducted resource surveys. The remaining 6,181 is the commercial total catch OY. The open access allocation of 9.4 percent of the commercial OY, results in a total catch OY of 581 mt. The limited entry allocation of 90.6 percent of the commercial OY, results in a total catch OY of 5,600 mt. The limited entry OY is further divided with 58 percent (3,248 mt) allocated to the trawl fishery and 42 percent (2,352 mt) allocated to the nontrawl fishery. For the first time in 2000, discard rates will be applied by sector to obtain landed catch value.

f/Sablefish in the Conception area has an ABC (425 mt) based on historical landings. To address uncertainty in stock assessment due to limited information, the ABC was reduced by 50 percent to obtain the OY (212 mt). There are no limited entry or open access allocations in the Conception area at this time.

g/Dover sole north of 36° N. lat. was assessed as a unit in 1997 and provided an ABC (7,151 mt) for landed catch based on a F40% Fmsy proxy. The Conception area ABC (1,053 mt) is at the level established in the original FMP, and was based on average landings. To address uncertainty in stock assessment due to limited information, the Conception area landed catch ABC was reduced by 50 percent to obtain the landed catch value. The ABC in this table represents total catch and was determined by estimating that 5 percent of the total catch was discarded to obtain the landed catch. Therefore, the coastwide ABC and total catch OY is 7,677 mt. The OY is further reduced by 67 mt as compensation to vessels that conducted resource surveys, resulting in a commercial OY of 7,610 mt.

h/Petrale Sole was believed to be at 42 percent of its unfished biomass following a 1999 assessment. For 2000, the final ABC for the Vancouver-Columbia area (1,262 mt) is based on a F40% Fmsy proxy. The ABCs for the Eureka, Monterey, and Conception areas (1,500 mt) continues at the same level as 2000.

i/Pacfic ocean perch (POP) was designated as overfished in 1999. The ABC (1541 mt) is based on the 2000 assessment for the Vancouver-Columbia area (1,523 mt at F50% Fmsy proxy), plus 18 mt for the Eureka area. The 2001 OY of 303 mt for the Vancouver-Columbia-Eureka area was set in the rebuilding plan. Discards are assumed to be 16 percent for a landed catch value of 255 mt.

j/ Shortbelly rockfish remains an unexploited stock and is difficult to assess quantitatively. The 1989 assessment provided 2 alterative yield calculations of 13,900 mt and 47,000 mt. NMFS surveys indicate poor recruitment in most years since 1989, indicating low recent productivity and a naturally declining population in spite of low fishing pressure. The ABC and OY therefore are

reduced to 13,900 mt, the low end of the range in the assessment.

k/Widow rockfish is believed to be at 24 percent of its unfished biomass indicating that its overfished at this time. The ABC (3,727 mt) is based on the 2000 assessment with a F50% Fmsy proxy. Two OY options were presented to the Council ranging from 2,864 (Based on F50% Fmsy proxy and the 40-10 harvest policy) to 1,775 mt (based on F65% Fmsy proxy and the 40-10 harvest policy). The Council adopted the average of the option range resulting in a total catch OY of 2,300 mt. The OY is reduced by 40 mt for the amount estimated to be taken as recreational catch, resulting in a commercial OY of 2,260 mt. The open access allocation (68 mt) is 3 percent of the commercial OY. The limited entry allocation (2,192 mt) is 97 percent of the commercial OY. The limited entry allocation is further reduced by 250 mt for anticipated bycatch in the offshore whiting fishery, and the remainder (1,942 mt) is reduced by 16 percent (311 mt) to account for trip limit induced discards, resulting in a landed catch equivalent for the limited entry fishery of 1,631 mt (excluding harvest in the whiting fishery).

l/Canary rockfish is believed to be at 22 percent of its unfished biomass in the north (north of Cape Blanco) and 8 percent of its unfished biomass in the south (south of Cape Blanco). Canary rockfish was declared overfished in 2000. In 1999, two assessments addressed the northern and southern portions of the stock. Although each area was assessed separately, there is no definitive evidence of separate northern and southern stocks. The coastwide ABC (228 mt) is based on a Fmsy proxy of F50%. The coastwide OY (93 mt) is based on the rebuilding plan and is the sum of 73 mt for the northern area, plus 20 mt for the southern area. The OY is reduced by 44 mt for the estimated recreational catch and 5 mt for research surveys, resulting in a commercial OY of 44 mt. Tribal vessels land a small amount of canary rockfish, but do not have a specific allocation at this time. The open access allocation (5 mt) is 12.3 percent of the commercial OY. The limited entry allocation (39 mt) is 87.7 percent of the commercial OY. The limited entry allocation is further reduced by 3 mt for anticipated bycatch in the offshore whiting fishery, and the remainder (36 mt) is reduced by 16 percent (6 mt) to account for trip limit-induced discards, resulting in a landed catch equivalent for the limited entry fishery of 30 mt (excluding harvest in the whiting fishery). However, the specific open access/limited entry allocation has been suspended during the rebuilding period as necessary to meet the overall rebuilding target while allowing harvest of healthy stocks.

m/Chilipeper rockfish - the ABC (2,700 mt) for the Monterey-Conception area is based on the 1998 stock assessment with the application of F50% Fmsy proxy. Because the biomass is believed to be above 40 percent of unfished, the default OY could be set equal to the ABC. However, the OY is set at 2,000 mt, near the recent average landed catch, to discourage effort on chilipepper which is known to have bycatch of bocaccio rockfish. The OY is reduced by 15 mt for the amount estimated to be taken in the recreational fishery, resulting in a commercial OY of 1,985 mt. Open access is allocated 44.3 percent (879 mt) of the commercial OY and limited entry is allocated 55.7 percent (1,106 mt) of the commercial OY. The assumed discard in the limited entry fishery is 16 percent, resulting in a landed catch value of 929 mt.

n/Bocaccio rockfish is believed to be at 2 percent of its unfished biomass and was designated as overfished in 1999. The ABC of 122 mt is based on a F50% Fmsy proxy. The OY (100 mt) is based on the rebuilding plan which is designed to rebuild the stock to MSY in 38 years. The OY is reduced by 48 mt for the amount estimated to be taken as recreational harvest, resulting in a 52 mt commercial OY. No discard amount is assumed within this OY.

o/Splitnose rockfish (also called "rosefish") - The 2001 ABC of 615 mt in the

southern area (Monterey-Conception) is based on the Fmsy proxy of F50%. The 461 mt OY for the southern area reflects a 25 percent precautionary adjustment because of the less rigorous assessment for this stock. In the north, splitnose is included in the minor rockfish OY. The assumed discard is 16 percent for a landed catch value of 387 mt.

p/Yellowtail rockfish is believed to be at 63 percent of its unfished biomass. The ABC of 3,146 mt is based on a 2000 stock assessment for the Vancouver-Columbia-Eureka areas with the Fmsy Proxy of F50%. The OY (3,146 mt) was set equal to the ABC. To derive the commercial OY (3,086 mt) the OY is reduced by 60 mt, the amount estimated to be taken in the recreational fishery. The open access allocation (256 mt) is 8.3 percent of the commercial OY. The limited entry allocation (2,830 mt) is 91.7 percent of the commercial OY. The limited entry landed catch allocation (1,810 mt) is determined by subtracting 675 mt for anticipated bycatch in the whiting fishery then deducting 16 percent from the remainder.

q/Thornyheads - The treaty tribes estimate that 3-4 mt of thornyheads will be taken in 2001 under a trip limit of 300 lb per trip. This small amount is not subtracted from the thornyhead OYs at this time.

r/Shortspine thornyhead was believed to be at 32 percent of its unfished biomass in 1999. The ABC (757 mt) in the north (Vancouver-Columbia-Eureka-Monterey) is based on a synthesis of two stock assessments conducted in 1998 with the application of a F50% Fmsy proxy. The OY (689 mt) is based on applying the 40-10 harvest policy because the biomass is in the precautionary zone. The commercial OY is reduced by 4.1 mt deducted for compensation fishing as compensation to vessels that conducted resource surveys. Open access is allocated 0.27 percent (2 mt) of the commercial OY and limited entry is allocated 55.7 percent (683 mt) of the commercial OY. A 20 percent rate of discard is applied to the limited entry allocation to obtain the landed catch value of 546 mt.

s/Shortspine thornyhead - A separate ABC (120 mt) is established for the Conception area and is based on historical catch for the portion of the Conception area north of 34° 27' N. lat. (Point Conception). To address uncertainty in the stock assessment due to limited information, the ABC was reduced by 50 percent to obtain the OY(62 mt). There is no ABC or OY for the southern Conception area.

t/Longspine thornyhead is believed to be above 40 percent of its unfished biomass. The ABC (2,461 mt) in the north (Vancouver-Columbia-Eureka-Monterey) is based on the average of the 3-year individual ABCs at a F50%. The total catch OY (2,461 mt) is set equal to the ABC. The Commercial OY (2,453 mt) is determined by deducting 8 mt for compensation to vessels that conducted resource surveys. To derive the landed catch equivalent of 2,043 mt, the limited entry allocation is reduced by 17 percent (410 mt) for estimated discards.

u/Longspine thornyhead - A separate ABC (390 mt) is established for the Conception area and is based on historical catch for the portion of the Conception area north of 34°27' N. lat. (Point Conception). The ABC was reduced by 50 percent to obtain the OY (195 mt). This was done to address uncertainty in stock assessment due to limited information. There is no ABC or OY for the southern Conception Area.

v/Cowcod in the Conception area was assessed in 1999 and is believed to be less than 10 percent of its unfished biomass and was therefore declared as overfished in 2000. The ABC in the Conception area (5 mt) is based on the 1999 assessment, while the ABC for the Monterey (19 mt) is based on average

landings from 1993-1997. An OY of 4.8 (2.4 mt in each area) was set to allow for rebuilding.

w/Darkblotched rockfish was assessed in 2000 and is believed to be at 22 percent of its unfished biomass. The stock is considered to be overfished at this time. Historical catch assumptions from 1965-1978 affect the estimate of unfished biomass and a ABC range is presented at this time. The lower ABC (302 mt) is based on the assumption that 10 percent of the red rockfish catch during the 1960s and 1970s was darkblotched rockfish; the upper ABC (349 mt) assumes 0 percent was darkblotched. The OY (130 mt) is the constant annual catch that would rebuild the stock in 10 years, based on the assumption that 5 percent of the catch was darkblotched. Open access is allocated 2.3 percent (3 mt) of the commercial OY and limited entry is allocated 97.7 percent (127 mt) of the commercial OY (130 mt). Limited entry discard is assumed to be 16 percent of the allocation resulting in a limited entry landed catch value of 106 mt.

x/Minor rockfish north includes the "remaining rockfish" and "other rockfish" categories in the Vancouver, Columbia, and Eureka areas combined. These species include "remaining rockfish", which generally includes species that have been assessed by less rigorous methods than stock assessment, and "other rockfish", which includes species that do not have quantifiable assessments. The ABC is the sum of the individual "remaining rockfish" ABCs plus the "other rockfish" ABCs. To obtain total catch OY (3,137 mt), the remaining rockfish ABCs were reduced by 25 percent and the other rockfish ABCs were reduced by 50 percent. This was a precautionary measure due to limited stock assessment information. The OY is reduced by 645 mt for the amount estimated to be taken in the recreational fishery, resulting in a commercial OY of 2,492 mt. Open access is allocated 9.6 percent (239 mt) of the commercial OY and limited entry is allocated 90.4 percent (2,253 mt) of the commercial OY. The discard is assumed to be 16 percent (353 mt), resulting in a landed catch value of 2139 mt.

y/Minor rockfish south includes the "remaining rockfish" and "other rockfish" categories in the Monterey and Conception areas combined. These species include "remaining rockfish", which generally includes species that have been assessed by less rigorous methods than stock assessment, and "other rockfish", which includes species that do not have quantifiable assessments. The ABC (3,556 mt) is the sum of the individual "remaining rockfish" ABCs plus the "other rockfish" ABCs. To obtain total catch OY (2,040 mt), the remaining rockfish ABCs were reduced by 25 percent and the other rockfish ABCs were reduced by 50 percent. This was a precautionary measure due to limited stock assessment information. The OY is reduced by 950 mt for the amount estimated to be taken in the recreational fishery, resulting in a commercial OY of 1,090 mt. Open access is allocated 44.3 percent (483 mt) of the commercial OY and limited entry is allocated 55.7 percent of the commercial OY.

z/Bank rockfish -- The ABC is 350 mt which is based on a 2000 assessment for the Monterey and Conception areas. This stock contributes 200 mt towards the minor rockfish OY in the south.

aa/Black rockfish -- the ABC (1,115 mt), which is based on a 2000 assessment, is the sum of the assessment area (615 mt) plus the average catch in the unassessed (500 mt). This stock contributes 865 mt towards the minor rockfish OY in the north.

bb/Blackgill rockfish is believed to be at 51 percent of its unfished biomass. The ABC for the Conception area (268 mt) was based on a Fmsy proxy of F50%, and 75 mt were added for the Monterey area. The ABC for the Monterey area is the OY it reduced by 25 percent for precautionary measures because of lack of

information. This stock contributes 306 mt towards the minor rockfish south OY.

cc/"Other rockfish" includes rockfish species listed in 50 CFR 660.302 and California scorpionfish. The ABC is based on the 1996 review of commercial Sebastes landings and includes an estimate of recreational landings. These species have never been quantifiably assessed.

dd/"Other fish" includes sharks, skates, rays, ratfish, morids, grenadiers, and other groundfish species noted above in footnote b/.

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ABC Policy and Overfishing

The Magnuson-Stevens Act requires the FMP to prevent overfishing. Overfishing is defined in the guidelines based on the Magnuson-Stevens Act National Standards for implementing the Magnuson-Stevens Act (63 FR 24212, May 1, 1998) as exceeding the fishing mortality rate (also known as the ''exploitation rate'') needed to produce the maximum sustainable yield (Fmsy). In 2001 as in 2000, the Council continued its use of default exploitation rates as a proxy for Fmsy. Thus, the 2001 ABCs are set at the maximum sustainable yield (MSY) proxy. The OYs are set at levels that are expected to prevent overfishing, i.e., levels equal to or less than the ABCs, according to the Council's default OY policy (described later in this document).

In spring 2000, the Council's Scientific and Statistical Committee (SSC) sponsored a workshop to review the Council's groundfish exploitation rate policy. The workshop explored the historic use of different fishing mortality (F) rates, and found that the Council's past practices have generally changed in correlation with new information from and perceptions within the scientific community. An F rate that is sustainable over time would provide a relatively constant annual rate of harvest, yet would allow the stock to maintain itself, accounting for reproduction and natural mortality. Starting in the early 1990s, the Council used a standard harvest rate of F35%, which is the F rate that reduces spawning potential per recruit to 35 percent of the unfished stock's spawning potential per recruit. (Usually the size of a stock's biomass is discussed in terms of spawning potential.) Reducing the spawning potential per recruit is not the same thing as reducing the overall population size to 35 percent of the unfished population size.

A fishing rate of F35% can mean very different things for different stocks because it is a relationship dependent on the productivity of a particular stock. Highly productive stocks have individuals that reach maturity quickly and produce many young that then survive to an age when they are large enough to be caught in the fishery (recruitment). These stocks may be fished at F35% and have a higher percent of the total adult population harvested each year than a less productive stock fished at F35%. Harvest rate policies must account for several complicating factors, including the age and size at which individuals in a stock reach maturity, the relative fecundity of mature individuals over time, and the optimal stock size for the highest level of productivity within that stock.

The SSC's workshop participants reported that new scientific studies in 1998 and 1999 had shown that the F35% and F40% rates used by the Council had been too aggressive for Pacific coast groundfish stocks, such that some groundfish stocks could not maintain a viable population over time. A 1999 study, ''The Meta-Analysis of the Maximum Reproductive Rate for Fish Populations to Estimate Harvest Policy; a Review'' (Myers, *et al.*) showed that Pacific coast groundfish stocks, particularly rockfish, have very low productivity compared to other, similar species worldwide. One prominent theory about the reason for this low productivity is the large-scale, North Pacific climate shifts that are thought to cycle Pacific coast waters through warm and cool phases of 20-30 years duration. Pacific coast waters shifted to a warm phase around 1977-78, with ocean conditions less favorable for Pacific coast groundfish and other fish stocks.

After an intensive review of historic harvest rates, and current scientific literature on harvest rates and stock productivity, the SSC workshop concluded that F40% is too aggressive for many Pacific coast groundfish stocks, particularly for rockfish. For 2001 and beyond, the Council adopted the SSC's new recommendations for harvest policies of: F40% for flatfish and whiting, F50% for rockfish (including thornyheads) and F45% for other groundfish such as sablefish and lingcod. The Council also adopted a more precautionary OY policy for stocks with less rigorous stock assessments. In previous years, Council policy had been to assume that fishing mortality on these stocks was 75 percent of total mortality (fishing mortality + natural mortality). Based on SSC recommendations, the Council reaffirmed this policy, but added another precautionary adjustment, requiring that OYs for these stocks be set at 75 percent of ABCs. These changes toward more conservative harvest rates have resulted in lower ABCs and OYs for many stocks in 2001 than in 2000 (see footnotes for Table 1).

The 2001 ABCs, which are based on the best available scientific information, available include both landed catch and estimated discards, to represent total fishing mortality. ABCs apply only to U.S. waters where the assessments included Canadian waters. Stock assessment information considered in determining the ABCs is available from the Council and was made available to the public before the Council's November 2000 meeting, in stock assessment documents and reports, which are compiled into the Council's SAFE document (see **ADDRESSES**). Additional information is found in the EA prepared by the Council for this action, in the SAFE document for the 2001 specifications, and in documents available at the September and November 2000 Council meetings.

Default OY Policy

In 1999, the Council adopted a ''40-10 precautionary policy'' for setting OY that is intended to prevent species from becoming overfished. A stock that is at 40 percent of its unfished biomass is said to be at B40%. Bmsy is the stock biomass level required to achieve MSY. The Council uses B40% as as a default proxy for Bmsy for stocks with an unknown Bmsy.

According to the Council's OY policy, if the stock biomass is larger than Bmsy, the OY may be set equal to or less than ABC. A stock with a current biomass between 25 percent of the unfished level and Bmsy (the precautionary threshold)

is said to be in the ''precautionary zone.'' The Council's default OY harvest policy reduces the fishing mortality rate when a stock is at or below its precautionary threshold. The further the stock is below the precautionary threshold, the greater the reduction in OY will be relative to the ABC, until, at B10%, the OY would be set at zero. This is, in effect, a default rebuilding policy that will foster quicker return to the Bmsy level than would fishing at the ABC level. However, the Council may recommend setting the OY higher than the default OY harvest policy specifies, if justified, and as long as the OY does not exceed the ABC (Fmsy) harvest rate and is consistent with the requirements of the Magnuson-Stevens Act and complies with the National Standard Guidelines. Additional precaution may be added on a case-by-case basis at any level of current biomass that may be warranted by uncertainty in the data or by higher risks of being overfished.

If a stock falls below 25 percent of its unfished biomass (B25%), it is considered overfished, and the Magnuson-Stevens Act requires the Council to develop a rebuilding plan within 1 year. Rebuilding plans for overfished species have stock-specific allowable harvest rates, although those rates may still be consistent with this ''40-10 default OY'' policy.

2001 ABCs and OYs

The species that had ABCs and OYs in 2000 continue to have ABCs and OYs in 2001. New assessments were completed and ABCs and OYs were developed for darkblotched rockfish, widow rockfish, yellowtail rockfish, POP in the Vancouver and Columbia areas, and for lingcod, for which separate ABCs were calculated for the northern (Vancouver-Columbia) and southern (Eureka-Monterey-Conception) areas based on a coastwide assessment.

Five groundfish stocks have been designated as ''overfished'': POP, bocaccio (*S. paucispinis*), lingcod, canary rockfish (*S. pinniger*), and cowcod (*S. levis*). The OYs for overfished species have been set to be consistent with the rebuilding plans for those species. In 2001, two additional species, darkblotched and widow rockfish, will be designated as overfished. The OYs for darkblotched and widow rockfish are set at extremely low levels in anticipation of the rebuilding plans that will be required in 2002. In order to reduce associated harvest of bocaccio, the chilipepper OY is reduced by almost 25 percent.

Minor rockfish OYs are subdivided into nearshore (shallowest), shelf, and slope (deepest) categories, according to the approximate depths where those species are caught. This separation results in six distinct OYs for minor rockfish, north and south of 40°10' N. lat. For species that have rudimentary or no assessments, precautionary adjustments to the OYs continue to be made as in 2000. The 40-10 harvest policy continues to be used for assessed stocks where the biomass is estimated to be between 25 and 40 percent of the unfished biomass. Minor rockfish OYs and allocations are incorporated in Table 1a by category. Rockfish species in the nearshore, shelf, and slope categories are listed in paragraph IV.A.(21) and minor rockfish species are listed in Table 2.

As a result of the constraining management measures imposed to protect and rebuild overfished species, a number of the OYs may not be achieved in 2001, particularly for those shelf rockfish species that are not overfished but that are caught with species that are overfished. It is difficult to forecast what the actual catch of these relatively healthy species will be, but to lower the OYs for these species could unnecessarily constrain the fishery.

Several changes were made during 2000 that affect the ABCs and OYs for 2001: (1) Adoption of new default harvest rates with the default Fmsy proxy of F50% for rockfish and F40% for Pacific whiting and flatfish, and F45% for other groundfish species, resulting in lower harvest recommendations for many species; (2) the use of Experimental Data Collection Program (EDCP) data to derive new discard rates for shortspine (20 percent) and longspine thornyhead (17 percent), and new sector specific discard rates for sablefish north of 36° N. lat. that affect the landed catch OY; (3) completion of a new assessment for darkblotched rockfish, which raised uncertainty about historical catch during the 1960s and 1970s, resulting in an ABC range with the lower ABC based on the assumption that 10 percent of the historical red rockfish catch in foreign fisheries was darkblotched rockfish and the upper ABC based on the assumption that 0 percent was darkblotched; and (4) Adoption by the Council of rebuilding plans for canary rockfish and cowcod.

In 2001, as in 2000, unless otherwise specified, OYs and allocations represent total catch, and, where possible, the expected landed catch equivalent is calculated. This approach provides greater management flexibility if new information becomes available inseason because managers will then be able to modify discard estimates and management measures inseason. Derivations of the ABCs and OYs for the individual groundfish species are explained in detail in Council documents from their September 2000 and November 2000 meetings, and in the Council's SAFE document (which includes the most recent stock assessments) and are summarized in this document in Table 1a. Derivations of commercial HGs, limited entry and open access allocations, and landed catch equivalents appear in the footnotes to Table 1a, listed at the end of Table 1b.

Management measures designed to rebuild overfished species, or to prevent overfishing or to prevent a species from becoming overfished may restrict the harvest of relatively healthy stocks that are harvested with the overfished species. Consequently, fishers may not be allowed to harvest the entire OYs of these associated healthy stocks.

Determinations of Overfished Stock Status and Rebuilding Plans

The status of the resource is evaluated against the requirements of the Magnuson-Stevens Act, the guidelines based on the National Standards, and the FMP. A species is overfished if its current biomass is less than 25 percent of the unfished biomass level. The Magnuson-Stevens Act requires that a rebuilding plan be prepared within one year after the Council is notified that the species is overfished.

Requirements for developing overfished species rebuilding plans are addressed in Amendment 12 to the FMP, which NMFS approved on December 7, 2000. Before Amendment 12 was submitted for public review (September 8, 2000, 65 FR 54475), NMFS had approved the Council's first three rebuilding plans for lingcod, bocaccio, and POP (September 5, 2000, 65 FR 53646). During NMFS review of Amendment 12, the agency considered whether these three rebuilding plans met the requirements of Amendment 12 and concluded that they did not. The revocation of NMFS' prior approval of the three rebuilding plans was described in the final rule to implement Amendment 12 (65 FR 82947 December 29, 2000). NMFS determined that while the three rebuilding plans specify adequately protective harvest limits for these three species, the rebuilding plans did not meet all of the rebuilding plan content requirements described in Amendment 12. The groundfish fisheries will continue to operate under measures implementing the rebuilding plans for lingcod, bocaccio, and POP in 2001. However, NMFS has instructed the Council to re-submit rebuilding plans for these three species by January 1, 2002. NMFS has also notified the

Council via this **Federal Register** document that two additional species (dark blotched rockfish and widow rockfish) are overfished and that the Council must submit rebuilding plans for these two species within a year of this notification.

For 2001, the bocaccio OY is set at 100 mt, consistent with its initial rebuilding plan. The initial POP rebuilding plan indicated that the stock was at 13 percent of its unfished biomass, and that with an initial annual harvest of about 300 mt, the stock could be rebuilt to Bmsy within 47 years. A new POP stock assessment in 2000 estimated that the POP stock may be more abundant than suggested by the stock's 1998 assessment, which had led to the designation of POP as overfished. The 2000 assessment indicates that the POP stock is no longer below the overfished threshold, and that it may be possible to rebuild POP to Bmsy within 10 years. Although the new stock assessment supports a higher annual harvest than specified in the rebuilding plan, the SSC recommended that the Council continue to set the OY consistent with the current rebuilding plan in 2001, and re-evaluate the rebuilding scenario for 2002. The Council concurred with the SSC, and recommended an OY of 303 mt for 2001, in keeping with the initial POP rebuilding plan.

Lingcod also underwent a new, coastwide assessment in 2000. Previously, separate lingcod assessments had been done for waters north and south of Cape Blanco, with most efforts concentrated in the north. The lingcod rebuilding plan and last year's harvest management were based on a 1997 northern area assessment and an initial southern area assessment in 1999. Because of the strong history of northern area assessments and the newness of the southern area assessment, the lingcod rebuilding plan applied precautionary exploitation rates from the northern stock to the southern area biomass to set a southern ABC. For 2000, the lingcod ABCs were 450 mt in the north and 250 mt in the south, and the combined coastwide OY was 378 mt. An OY of 378 mt was set by using a constant exploitation rate that was estimated to provide a 60 percent likelihood that lingcod stocks would rebuild to Bmsy within 10 years. The initial rebuilding plan recognized that a new assessment of the entire coastwide stock was scheduled for 2000, and the Council would use the results to make any necessary adjustments for the 2001 fishing year.

While the lingcod rebuilding plan formally began in 2000, the Council had set fairly low lingcod OYs in several years prior to 2000. The 2000 lingcod stock assessment determined that lingcod stocks have responded favorably to earlier rebuilding efforts. Current assessment results show a higher spawning biomass than seen in the 1997 assessment, which is partially responsible for the higher northern lingcod ABC in 2001. The 2000 lingcod assessment finalized and updated information from the southern area to show that although southern area stocks are below the overfished threshold, they are not as depleted as the northern area stocks. Washington Department of Fish and Wildlife (WDFW) has extensive involvement in lingcod assessments, and for the 2000 assessment, that agency conducted an exhaustive analysis of its historic lingcod aging methods. WDFW improved and updated its aging methods, and found that the new methods showed a younger and more productive stock than portrayed in earlier assessments for the northern area. For 2001, the northern ABC is 610 mt and the southern ABC is 509 mt. The combined coastwide lingcod OY is 611 mt, which is the harvest level derived from a constant exploitation rate that is expected to have a 60-percent likelihood of rebuilding the stock to Bmsy within 9 years. Thus, although the lingcod OY was increased in 2001, the harvest parameters are in keeping with the initial lingcod rebuilding plan.

In the 2000 annual specifications and management measures document, NMFS announced its determination that two additional species were considered overfished: canary rockfish and cowcod (January 4, 2000, 65 FR 221). The Council prepared rebuilding plans for these two species and will submit those rebuilding plans for NMFS review in January 2001. After receipt of these plans, NMFS will publish a Notice of Availability in the **Federal Register** with a 30-day public comment period before making a decision to either approve or disapprove the rebuilding plans. Rebuilding measures for all five overfished species, plus preliminary rebuilding measures for darkblotched and widow rockfish, are included in the 2001 management measures.

The Council approved a canary rockfish rebuilding plan and 2001 OY that will limit total coastwide harvest of the canary rockfish stock to 93 mt annually for the next 2 years. This plan envisions a 57-year rebuilding period, although the actual length of time to rebuild the stock depends on its future reproductive successes and annual catch levels. The adopted rebuilding period and 2001 OY are based on a constant annual catch and a precautionary assumption about the stock's relative reproductive success. At the September meeting, the Council considered a more pessimistic recruitment forecast that would have resulted in an annual OY of 60 mt. An analysis in September-October of the regulations that would be needed to achieve this lower OY revealed that virtually all commercial fishing for groundfish and much commercial fishing for non-groundfish species on the continental shelf would have to be eliminated. Complete closure of these commercial fisheries would have had dramatic adverse economic effects on fishing industries and communities. Moreover, such a closure would have created a significant allocation problem between the recreational and commercial sectors that would have been difficult to address in such a short period of time.

After consulting with the canary rockfish stock assessment scientist at its November meeting, the Council adopted a slightly less pessimistic forecast for recent recruitment, which yielded an annual OY of 93 mt. However, the Council took a precautionary stance and adopted the OY for only the next 2 years. During that time, NMFS will conduct another survey of the groundfish resources. This survey is expected to produce information directly relevant to the uncertainty regarding recent recruitment. The new information will be incorporated into an updated stock assessment in 2002, and the canary rockfish OY will be subsequently adjusted to meet rebuilding targets. The rebuilding plan calls for annual review of the various fisheries that take canary rockfish, and includes a mandatory review of the entire plan after two years. Moreover, the plan requires the Council to consider all sources of canary rockfish fishing mortality in order to reduce the effect of the fisheries on the stock, including bycatch in the Pacific whiting, fishery, salmon troll, and pink shrimp fishery.

In order to achieve the OY called for by canary rockfish rebuilding, the Council is controlling incidental catch of canary rockfish, rather than allocating directed harvest of canary rockfish. Adhering strictly to the open access/limited entry allocation of canary rockfish that was established under the limited entry program (Amendment 6 to the FMP) does not allow this flexibility. However, Amendments 12 and 13 to the groundfish plan, which were approved in December 2000, recognize that adhering to these allocations may not be appropriate or possible for fisheries being rebuilt, and authorize deviation

from these allocations during the rebuilding period. In order to meet canary rockfish rebuilding goals while equitably distributing the adverse effects of rebuilding among the fleets, the Council has recommended suspending the open access/limited entry allocation for canary rockfish. The Council has not set a specific open access/limited entry canary rockfish allocation, but instead has crafted the most reasonable set of management measures to achieve rebuilding. Taking these steps to begin rebuilding is particularly appropriate for canary rockfish, which is taken incidentally in several state-managed, open access fisheries, such as the pink shrimp trawl fishery and the salmon troll fishery. The Council does not directly control the amount of canary rockfish taken (although it does control the amount landed) in the state-managed fisheries.

The Council's rebuilding measures for canary rockfish and cowcod and the ABCs, OYs, and management actions recommended for 2001 are consistent with the FMP and the canary rock and cowcod rebuilding plans. The draft rebuilding plans endorsed by the Council are summarized as follows:

Canary Rockfish

Areas: coastwide

Status of stock: 8 to 22 percent of unfished biomass.

Maximum allowable years to rebuild to MSY: 58 years

Probability of rebuilding to MSY biomass in 57 years: 52 percent

Expected time to rebuild: 57 years.

Fmsy proxy: F50%

ABC in 2001: 228 mt

OY in 2001: 93 mt

Management measures for 2001: Canary rockfish are primarily a shelf rockfish species, but may also move into deeper waters as they age, commonly ranging from 25 fathoms (60.96 m) to 250 fathoms (609.6 m). Historic fisheries for canary rockfish have been concentrated in waters of 50-150 fathoms depth. Their range is from the northern Baja California waters to the western Gulf of Alaska, and they may be caught either in large pelagic schools or dispersed along the rocky bottom. The large range and varied habits of canary rockfish make selecting rebuilding measures particularly difficult. Canary rockfish are caught either directly or incidentally in most West Coast groundfish fisheries. Of the 93 mt OY, 5 mt are reserved for harvest associated with scientific research, 44 mt are expected to be taken in the recreational fisheries, and 44 mt are expected to be taken as incidental catch in the commercial fisheries.

In California and Oregon recreational fisheries, the rockfish bag limit is 10 fish, no more than 1 of which may be canary rockfish; off Washington the bag limit is 10 fish, no more than 2 of which may be either canary rockfish or yelloweye rockfish. California recreational fisheries will also close for 2 months (January-February) south of Point Conception (and possibly 2 months at the end of the year), and for 4 months (January-April) between Point Conception and Cape Mendocino, with some fishing allowed shoreward of the 20-fathom depth contour. Historically, the bulk of the recreational canary rockfish landings have been made in California. Commercial fisheries for groundfish and for non-groundfish species that co-occur with canary rockfish have been restricted to minimize the incidental catch of canary rockfish. California hook-and-line commercial fisheries are closed during the same periods and in the same areas as the recreational fisheries. Moreover, new landings limits are introduced for the summer flatfish and mid-water yellowtail rockfish fisheries to reduce opportunities for incidental canary rockfish interception, and opportunities for fishing with large footrope bottom trawl gear are severely restricted. In the first few months of 2001, the states will be working with their shrimp trawl industry on using fish excluder devices to reduce incidental canary harvest in that fishery.

Cowcod

Areas: Point Conception to the U.S.-Mexico boundary.

Status of stock: 4-11 percent of unfished biomass.

Maximum allowable years to rebuild to MSY: 98.

Probability of rebuilding to MSY biomass in 98 years: 55 percent

Expected time to rebuild: 95

Fmsy proxy: F50%

ABC in 2001: 5 mt.

OY in 2001: 2.4 mt.

Management measures: Cowcod is a sedentary shelf rockfish species that ranges from waters off Washington state southward to Mexico, with several concentrated areas of abundance in waters around some of the islands and offshore banks of the Southern California Bight. Cowcod is one of the largest West Coast rockfishes, growing to 37 inches (95 cm), making it a prized recreational fisheries target. In commercial fisheries, cowcod is usually caught incidentally to other species, as it occurs too infrequently to target efficiently. All directed cowcod fishing opportunities have been eliminated in 2001. Retention of cowcod is prohibited for all commercial and recreational fisheries. To protect cowcod from incidental harvest, the Council has recommended two Cowcod Conservation Areas (CCAs) (the Eastern CCA and the Western CCA) in the Southern California Bight, delineated to encompass key cowcod habitat areas and known areas of high catches. Fishing for groundfish is prohibited within the CCAs, except that minor nearshore rockfish, cabezon, and greenling may be taken from waters where the bottom depth is less than 20 fathoms (36.9 m). A transportation corridor is provided through the Western CCA to allow commercial vessels fishing for slope rockfish and other groundfish west of the Western CCA to transport that groundfish through the Western CCA. The Western CCA is an area south of Point Conception that is bound by straight lines connecting the following points in the order listed:

33°50' N. lat., 119°30' W. long.;
33°50' N. lat., 118°50' W. long.;
32°20' N. lat., 118°50' W. long.;
32°20' N. lat., 119°30' W. long.;
33°00' N. lat., 119°30' W. long.;
33°00' N. lat., 119°50' W. long.;
33°30' N. lat., 119°50' W. long.;
33°50' N. lat., 119°30' W. long.

The transit corridor through the Western CCA is bounded on the north by the latitude line at 33°00'30'' N. lat., and on the south by the latitude line at 32°59'30'' N. lat.

The Eastern CCA is a smaller area west of San Diego that is bound by straight lines connecting the following points in the order listed:

32°40' N. lat., 118°00' W. long.;
32°40' N. lat., 117°50' W. long.;
32°30' N. lat., 117°50' W. long.;
32°40' N. lat., 118°00' W. long.

Overfishing

None of the 2001 ABCs are knowingly set higher than Fmsy or its proxy, none of the OYs are set higher than the corresponding ABCs, and the management measures herein are designed to keep harvest levels within specified OYs.

After the 1999 fishing season, NMFS determined that overfishing had occurred on three species of rockfish in that year: darkblotched rockfish, silvergrey rockfish, and yelloweye rockfish. Changes to the rockfish management structure in 2000 that divided minor rockfish into three species groups (nearshore, shelf, slope) were partially intended to ensure that those species would not be subject to overfishing harvest rates in 2000. The Council also adopted a policy for the 2000 specifications that had reduced

ABCs by 25 percent to determine OYs for those species with less rigorous stock assessments, and by 50 percent to determine OYs for those species with no stock assessment. These policies are continued in 2001.

Overfishing is difficult to detect inseason for many rockfish, particularly these minor rockfish species, because most are not individually identified on landing. Species compositions, based on proportions encountered in samples of landings, are applied during the year. However, final results are not available until after the end of the year.

Bycatch and Discards

The Magnuson-Stevens Act defines bycatch as ''fish which are harvested in a fishery, which are not sold or kept for personal use, and include economic discards and regulatory discards.'' In the Pacific Coast groundfish fishery and in many other fisheries, the term bycatch is commonly used to describe nontargeted species that are landed and sold or used. The term ''discard'' is used to describe those fish harvested that are neither landed nor used.

Groundfish management measures include provisions to reduce trip limit-induced discards and to account for those discards when setting ABCs and monitoring harvest levels. Discard rates are used to calculate an amount of assumed discard that is subtracted from the annual total catch OY to yield a landed catch equivalent. Although there is no exact measure of discard amounts in most fisheries, the assumed amounts are taken into account to prevent total harvest from exceeding the ABC. Certain species are also managed within mixed-stock groups, like the ''DTS complex'' of Dover sole, thornyheads, and sablefish. For groundfish multispecies management, trip limits are set to match the known species catch proportions, which may mean reducing trip limits on some of the more abundant species to reduce discards of less abundant species, or setting trip limits at levels that vary throughout the year according to when particular stocks are most aggregated.

Stock assessments and inseason catch monitoring are designed to account for all fishing mortality, including that resulting from fish discarded at sea. Discards in the fishery for whiting are well monitored and are accounted for inseason as they occur. In the other fisheries, discards caused by trip limits have not been monitored consistently, so discard estimates have been developed to account for this extra catch. A discard level of 16 percent of the total catch, previously measured for widow rockfish in a scientific study, is assumed for the commercial fisheries for widow rockfish, yellowtail rockfish, canary rockfish, and POP.

For 2001 fisheries, NMFS analyzed the results of the 1995 through 1998 EDCP, in which trawl vessels voluntarily fished for groundfish and either carried observers or completed detailed catch and discard logbooks. NMFS determined that EDCP data could provide a useful update for discard estimates applied to the ''DTS complex.'' Dover sole discard had been estimated at 5 percent of its total catch OY in 2000 and prior years, and data from the EDCP confirmed that estimate. Thornyhead discard estimates changed, however, from 9 percent to 17 percent of total catch OY for longspine thornyhead, and from 30 percent to 20 percent of total catch OY for shortspine thornyhead.

Sablefish is the fourth species in the DTS complex, and the only species in the complex with sector-specific allocations. In 2000 and prior years, an estimate of 10-percent discard had been taken off the top of the sablefish total catch OY before allocating the remaining catch between sectors. For 2001, the Council recommended first allocating the total catch OY between fishery sectors, and then applying sector-appropriate discard rates to each sector. Tribal sablefish longline fisheries were allocated 10 percent of the total catch OY (690 mt,), and then were discounted 3 percent of that allocation for discards, for a landed catch allocation of 669 mt. The remaining 90 percent (6,205 mt) of the total catch OY was discounted 24 mt for research, then divided between the open access (9.4 percent of the non-tribal OY, or 581 mt) and limited entry fisheries (90.6 percent of the non-tribal OY, or 5,600 mt). Open access sablefish fisheries are primarily hook-and-line daily trip limit fisheries, with an estimated discard rate of 8 percent, making the open access landed catch allocation 535 mt. The limited entry allocation is divided between the trawl sector (58 percent, or 3,248 mt) and the fixed gear sector (42 percent or 2,352 mt). EDCP data provided a trawl sector discard estimate of 22 percent, reducing the trawl landed catch allocation to 2,533 mt. The limited entry, fixed gear fishery lands most of its sablefish in a brief derby with few discard opportunities, similar to the tribal sablefish fisheries. Thus, the limited entry, fixed gear sablefish discard estimate is also 3 percent, reducing the allocation for that sector to 2,281 mt.

On December 21, 2000, NMFS approved Amendment 13 to the FMP. The amendment was intended to respond to Magnuson-Stevens Act bycatch provisions. NMFS published a proposed rule to implement Amendment 13 on November 21, 2000 (65 FR 69898), which included a full retention program for the at-sea whiting fisheries and changes to the annual management measures framework to allow better protection of overfished species from incidental catch. NMFS will soon publish a final rule that will create a regulatory framework for an observer program in the shore-based groundfish fisheries. In early 2001, the agency will be working with the three West Coast states and the interested public to develop an observer coverage plan for the purpose of gathering total catch information. NMFS hopes to place observers on groundfish vessels in summer/fall 2001. All of these efforts are expected to improve and update discard information, data on mixed-stock complex compositions, and background data for stock assessments.

II. Limited Entry and Open Access Fisheries

The FMP established a limited entry program that, on January 1, 1994, divided the commercial groundfish fishery into the limited entry and open access sectors, each with its own allocations and management measures. Limited entry and open access allocations are calculated according to a formula specified in the FMP, which takes into account the relative amounts of a species taken by each component of the fishery during the 1984-1988 limited entry window period.

Groundfish species that had limited entry and open access allocations in 2000 continue to be allocated between the two sectors in 2001. As explained earlier in the section on rebuilding plans, the limited entry/open access allocation for canary rockfish is being suspended during the rebuilding period as necessary in order to allow the Council the flexibility to develop management measures to allow access to healthy stocks while protecting canary rockfish. All OYs, and all limited entry and open access allocations are expressed in terms of total catch. In 2001, as in 2000, estimates of trip-limit induced discards that previously were taken ''off the top'' before setting the limited entry and open access allocations, will instead be deducted only from the limited entry allocations for purposes of estimating the landed catch equivalents. Estimates of discards will be applied separately inseason to the limited entry and open access allocations as data become available. Landed catch equivalents are the harvest goals used when adjusting trip

limits and other management measures during the season. Estimated bycatch of yellowtail rockfish and widow rockfish in the offshore whiting fishery is also deducted from the limited entry allocations to determine the landed catch equivalents for the target fisheries for widow and yellowtail rockfish. Although this revised process complicates the calculation of the landed catch equivalents for the limited entry allocations, it is intended to more appropriately apply the discard estimates to the fleet responsible for the discards. Discards in most open access fisheries are believed to be small, and no discard estimates are applied to the open access fishery at this time. However, they may be applied during the season as information becomes available.

Open Access Allocations

The open access fishery is composed of vessels that operate under the OYs, quotas, and other management measures governing the open access fishery, using (1) exempt gear or (2) longline or pot (trap) gear fished from vessels that do not have limited entry permits endorsed for use of that gear. Exempt gear includes all types of legal groundfish fishing gear except groundfish trawl, longline, and pots. (Exempt gear includes trawls used to harvest pink shrimp, spot, or ridgeback prawns (shrimp trawls) and, halibut or sea cucumbers south of Pt. Arena, CA (38°57'30≥ N. lat.).

Open access allocations are derived by applying the open access allocation percentages to the commercial OY. The commercial OY is the annual OY after subtracting any set-asides for recreational or tribal fishing or compensation for conducting resource surveys. For those species in which the open access share would have been less than 1 percent, no open access allocation is specified unless significant open access effort is expected.

Limited Entry Allocations

The limited entry fishery is the fishery composed of vessels using limited entry gear fished pursuant to the OYs, quotas, and other management measures governing the limited entry fishery. Limited entry gear includes longline, pot, or groundfish trawl gear used under the authority of a valid limited entry permit issued under the FMP, affixed with an endorsement for that gear. (Groundfish trawl gear excludes shrimp trawls used to harvest pink shrimp, spot prawns, or ridgeback prawns, and other trawls used to fish for California halibut or sea cucumbers south of Pt. Arena, CA.) A sablefish endorsement is also required to operate in the limited entry non-trawl regular or mop-up seasons for sablefish.

The limited entry allocation (in total catch) is the OY reduced by (1) set-asides, if any, for treaty Indian fisheries, recreational fisheries, or compensation fishing for participation in resource surveys (which results in the commercial OY or quota); and (2) the open access allocation. (Allocations for Washington coastal tribal fisheries are discussed in section V and, for whiting, at paragraph IV.B.(3).)

Following these procedures, the Regional Administrator calculated the amounts of the allocations that are presented in Table 1a to this document. Unless otherwise specified, the limited entry and open access allocations are treated as OYs in 2001. There may be slight discrepancies from the Council's recommendations due to rounding.

III. 2001 Management Measures

Before 2000, the major goals of groundfish management were to prevent overfishing while achieving the OYs and to provide year-round fisheries for the major species or species groups. Over time, however, it became apparent that a number of species could not continue to be harvested year-round at a constant harvest rate. New legislative mandates under the Magnuson-Stevens Act (as amended by the Sustainable Fisheries Act in 1996) gave highest priority to preventing overfishing and rebuilding overfished stocks to their MSY levels. The National Standard Guidelines at 50 CFR 600.310 interpreted this as ''weak stock management,'' which means that harvest of healthier stocks may need to be curtailed to prevent overfishing or to rebuild overfished stocks. Amendment 13 to the FMP, which was approved in December 2000, authorizes additional types of management measures to be adopted routinely with the annual management measures in order to achieve rebuilding.

Five FMP species have been declared overfished as of January 2000 (lingcod, bocaccio, POP, canary rockfish, and cowcod), and two more species are being declared overfished concurrent with publication of this document (darkblotched and widow rockfish). Of these species, canary rockfish is the most constraining, as its OY was reduced from 1,045 mt in 1999 to 200 mt in 2000, and to 93 mt in 2001. Canary rockfish is found coastwide on the continental shelf and is caught directly or incidentally in most West Coast fisheries (groundfish and non-groundfish. In order to rebuild these overfished species, the Council chose management measures to divert effort off the sea floor of the continental shelf, where lingcod, bocaccio, canary rockfish, cowcod, widow rockfish, and, to a lesser extent, POP and darkblotched rockfish occur. Management measures for 2001 are designed to orient these fisheries away from the shelf, while providing fishing opportunities on some, but not all, groundfish species throughout the year.

Management priorities for 2001 were guided by the following goals: (1) Prevent overfishing; (2) manage consistent with rebuilding plans for overfished species; (3) maximize harvest opportunities for non-depleted stocks while minimizing, to the extent practicable; the discard mortality of other species; (4) provide equitable harvest opportunity for both recreational and commercial sectors; (5) within the commercial fisheries, achieve limited entry and open access allocations, to the extent practicable and (6) maintain year-round commercial groundfish fishing opportunities to the extent possible.

A number of assumptions and considerations were involved in developing the management recommendations for 2001. As discussed earlier, the chief constraint for 2001 fisheries was the need to prevent directed and incidental canary rockfish harvest. Directed canary rockfish harvest can be eliminated by reducing trip limits to levels that make targeting canary rockfish unprofitable. However, reducing incidental interception of canary rockfish to minimal levels is much more difficult. For example, widow rockfish directed fishing opportunities in 2001 have been reduced because of its newly designated status as an overfished species, and reducing widow rockfish target levels is expected to also reduce incidental canary rockfish interception. Moreover, yellowtail rockfish, which is also often caught with canary rockfish, has lower trip limits this year then otherwise would have been required to take the yellowtail OY to minimize canary rockfish interception. In general, there are few yellowtail rockfish targeting opportunities for trawlers in 2001, and most yellowtail rockfish landings are allowed only when yellowtail is caught incidentally to flatfish landings or in directed midwater yellowtail fisheries. Furthermore, flatfish fisheries have been constrained by new trip limits, particularly in the summer months when canary rockfish is likely to be incidentally taken.

The Council has also continued its management strategy from 2000 that prohibited landings of many species by

vessels using large footrope trawl gear (footropes greater than 8 inches (20.5 cm) diameter). It is not possible to maintain a year-round fishery with bottom trawl gear for all groundfish species without an unacceptable level of incidental catch, and it is not possible to maintain a year-round commercial fishery if all (or even most) limited entry vessels participate all year.

Recreational fisheries effort has also been reduced to protect canary rockfish. A significant portion, 26 mt, of the 93 mt canary rockfish OY is expected to be taken in the California recreational fisheries. To constrain their recreational fisheries to even this catch level, California fishery managers recommended continuing the 2000 2-month fishery closure south of Point Conception, except for fishing for minor nearshore rockfish shoreward of the 20-fathom (36.9 m) depth contour (with the potential for an additional closure in the last 2 months of the year if needed). Between Point Conception and 40°10' N. lat., the fishery will be closed in March and April, and expanding to a partial closure in May-June, although fishing for minor nearshore rockfish shoreward of the 20-fathom (36.9 m) depth contour will be allowed. Additional changes to bag limits, hook limits, and size limits were also needed to reduce recreational canary rockfish harvest.

Cowcod protection measures described earlier in the section on cowcod rebuilding apply to all fisheries. Cowcod retention is prohibited for all fisheries and all gear types. Commercial and recreational groundfish fisheries are closed within the CCAs, except that fishing for nearshore rockfish is allowed inside 20 fathoms (36.9 m). The Council is also asking the state of California to further protect cowcod by restricting or prohibiting non-groundfish fisheries inside the CCAs.

Recreational fishing restrictions proposed for California are intended to ensure that fishing mortality will not exceed limits associated with rebuilding plans for bocaccio, canary rockfish, cowcod, and lingcod, while not restricting the fisheries so fully that charter vessels and associated firms are forced out of business. The 2-month closure off southern California is intended to reduce bocaccio catch but will provide some protection for all species. The 4-month closure off central California will provide additional protection needed for canary rockfish as well as reducing the catch of bocaccio and lingcod in that area. Reductions in bag limits and hook limits are also intended to reduce opportunities for fishers to intercept protected species. Closed CCAs will have incidental benefits in protecting bocaccio and other rockfish. Cowcod inhabit special types of habitat, and fishers (and charter operators) know well how to identify and avoid such habitat. Taken together with the proposed restrictions on commercial fisheries, the recreational fishery limits are expected to keep total fishing mortality under the established OYs.

Some commercial fishers have commented that they are being unfairly constrained relative to recreational fisheries, while some recreational fishers have commented that the commercial fisheries are being favored. In developing 2001 management measures, the Council sought a fair and equitable balance for the two sectors, and also sought to achieve needed reductions in total fishing mortality. The Council was concerned that further restrictions on recreational fishing (e.g., longer closures or lower bag limits) would prevent charter vessels operators from running charter fishing trips for a long enough period that they would go out of business. Under further restrictions, passengers may refuse to pay the price to fish or may not make enough trips in open seasons to allow operators to cover their costs. Not only would charter vessel operators be affected by changes to recreational fishery management, but related businesses would also likely suffer. The closed seasons generally cover the months that have historically accounted for the largest seasonal catches of bocaccio and other rockfishes.

Allowable commercial catches of many groundfish are even lower than in 2000, but the Council has tried to restructure the timing of differential trip limits to provide commercial fisheries with greater flexibility in their fishing patterns while not increasing the overall catches. Again, this restructuring is intended to limit the extent to which fishers would be driven out of business and related firms would suffer. Many commercial groundfish fishers have other fishing opportunities during the year, and these opportunities were taken into account. For example, the small-scale commercial fishers (and recreational fishers) in southern California would (under state regulations) still be able to fish for certain species in nearshore waters while the shelf is closed to protect overfished species.

Management measures for the limited entry fishery are found in section IV. Most cumulative trip limits, size limits, and seasons for the limited entry fishery are set out in Tables 3 and 4 of section IV. However, the limited entry nontrawl sablefish fishery, the midwater trawl fishery for whiting, and the hook-and-line fishery for black rockfish off Washington are managed separately from the majority of the groundfish species and are not fully addressed in the tables. Their framework management structure has not changed since 2000, except for the level of trip limits for sablefish and whiting, and is described in paragraphs IV.B.(2)-(4) of section IV. Other provisions for the 2000 fisheries not explicitly addressed above remain in effect for 2001 and are repeated in section IV of this document.

The following management measures, adopted this year as part of the annual management measures, are established as routine management measures: (1) Commercial trip limits that differ by gear type; (2) recreational size limits and hook limits; recreational fileting and dressing requirements for rockfish, cabezon, greenling, and lingcod; and (3) closed seasons/areas for all fisheries for all groundfish, rockfish, lingcod, and cowcod.

After hearing proposals and advice from its advisory entities and public testimony at its November 2000 meeting, the Council recommended the following actions for management in 2001.

Limited Entry Trawl

For the limited entry trawl fishery, the Council recommended a suite of gear and cumulative trip limits designed to encourage fishing with gear in times and areas where incidental catch of overfished or depleted species will be minimized. For 2001, the Council recommended continuing the use of differential trip limits for limited entry trawlers operating with different trawl gear configurations: bottom trawl with footropes greater than 8 inches (20.5 cm) in diameter; bottom trawl with footropes smaller than 8 inches (20.5 cm) in diameter; and midwater or pelagic trawl. Trawling with footropes that have roller gear or other large gear designed to bounce over tough rockpiles tends to allow those vessels greater access to areas where several of the overfished species congregate. Therefore, landings of shelf rockfish are prohibited if large footrope trawls (roller gear) are used (or on board the vessel); small amounts of shelf rockfish bycatch may be landed if small footrope trawls are used; and, targeting healthy shelf rockfish stocks is encouraged only if midwater trawls are used. This strategy of differential trip limits for different trawl gear types was used in 2000, and initial Oregon Department of Fish and Wildlife logbook data show a significant decrease in trawl activity in rocky areas of the

continental shelf. Cowcod prohibitions and closures apply to limited entry trawl vessels, although there are few limited entry trawl vessels operating south of Point Conception in CCA waters.

Chafing gear will continue to be prohibited on the body of small footrope trawls. Chafing gear protects the net from excess wear when it drags against rock piles or the sea floor. The prohibition against chafing gear makes the net more vulnerable to damage, and so encourages fishers to operate in less rocky areas.

Trawl vessels using large footrope gear (with footropes greater than 8 inches (20 cm) in diameter) are prohibited from landing nearshore and shelf rockfish and most flatfish species because their ability to fish in rocky areas would result in high incidental catch of species that cannot withstand additional fishing effort. Although vessels are not prohibited from using large footropes in nearshore and continental shelf areas, they are not allowed to retain and sell most of the species they would catch from those areas, which was a significant disincentive to operate there in 2000. Large footrope trawls may still be used on deepwater species of the continental shelf and slope, primarily Dover and rex soles, thornyheads, sablefish, and deepwater rockfish, fewer of the species needing protection in these areas would be encountered. During part of the year, predominantly winter months, large footrope trawls may also be used to harvest arrowtooth flounder and petrale sole. However, small footrope trawls are required for the rest of the year when these species are more likely to aggregate with overfished species (See Table 3).

Trip limits are imposed for arrowtooth flounder from January-April and from November-December to discourage targeting on POP, and on all flatfish species in the north in May-October to minimize canary rockfish bycatch. The lingcod trawl fishery is closed during January-April and November-December, with only an incidental catch level trip limit (400 lb (181 kg) per month) available from May-October. Lingcod closures in the winter will reduce the overall harvest and will protect spawning fish and males guarding their nests.

Another way the Council devised to allow harvest of relatively abundant stocks is through the use of midwater trawl gear. This gear is effective at harvesting certain species above the ocean floor with little or no bycatch of bottom-dwelling species such as canary rockfish. In fact, the Council believes that using midwater gear may be the best way to harvest chilipepper and yellowtail rockfish without catching canary rockfish. Consequently, larger 2-month cumulative trip limits are provided for vessels using midwater trawl gear to harvest yellowtail and chilipepper rockfish. If a fisher chooses to carry more than one type of trawl gear on board, any landing will be attributed to the gear on board with the most restrictive landing limit. To land the maximum amounts of yellowtail and chilipepper rockfish, vessels will be required to have only midwater trawl gear on board.

However, NMFS cannot guarantee that these higher midwater trawl limits will be available throughout the year, or in future years. NMFS cautions fishers to consider, before purchasing new gear, whether investing in new midwater trawl gear is cost effective. For the foreseeable future, the Council will be operating under the provisions of overfished species rebuilding plans, which will make it difficult for the Council to provide consistency in the fishery management measures it recommends from year to year.

Limited Entry Fixed Gear

Limited entry fixed-gear fisheries start the year with the same limits as the limited entry trawl fishery when there is no distinction based on type of trawl gear. It has the same limits as the small footrope trawl fishery when there is a trawl gear distinction, except for limits for sablefish, widow rockfish, yellowtail rockfish, chilipepper, and nearshore rockfish. Fixed gear cumulative trip limits for minor shelf rockfish, canary rockfish, bocaccio, and lingcod are the same as the cumulative trip limits for the small footrope trawl fishery except for the closed periods for the fixed gear fishery south of 40°10' N. lat. Cowcod prohibitions and closures apply to limited entry, fixed gear vessels.

Higher midwater trawl limits are not appropriate for fixed gear. Midwater trawls can be used to selectively harvest relatively large quantities of yellowtail and chilipepper rockfishes above the sea floor with minimal incidental catch of overfished species and at levels far exceeding recent landings by most fixed gear. There are no comparable and enforceable ways to modify fixed gear to keep it off the bottom and away from overfished species on the continental shelf.

The fixed gear fishery for widow rockfish is provided with a cumulative trip limit of 3,000 lb (1,361-kg) per month in 2001, between the 20,000-lb (9,072-kg) 2-month midwater trawl limit and the 1,000-lb (454 kg) per month small footrope trawl cumulative limit. However, the limit for the fixed gear fishery is higher than actual amounts landed by most fixed gear vessels in the past.

The fixed gear limit for yellowtail rockfish in 2001 is kept at the same level as for small footrope trawl gear, 1,500 lb (680 kg) per month. This limit will accommodate incidental catch rather than a target fishery. This limit will restrict the fixed gear fleet somewhat, but is intended and expected to minimize incidental canary rockfish catch.

The 2001 chilipepper limit of 2,500 lb (1,134 kg) per month is maintained at a lower level than trawl gear, consistent with recent landings, because bocaccio are caught in fixed gear fisheries for chilipepper.

Minor nearshore rockfish north of 40°10' N. lat. are managed to encourage fishing for black and blue rockfish, which are generally more abundant than other nearshore rockfish species. Thus, the limited entry fixed gear fishery for nearshore rockfish north of 40°10' N. lat. is 10,000 lb (4,536 kg) per 2 months, of which no more than 4,000 lb (1,814 kg) may be species other than black or blue rockfish.

The fixed gear sablefish fishery is managed under regulations at 50 CFR 660.323(a)(2) that provide for 2 seasons (the regular and mop-up seasons) during which cumulative trip limits apply. The rest of the year is designated for the ''daily trip limit'' (DTL) fishery, which is restricted by the pounds of sablefish that may be landed in each day, (300 lb (136 kg) north of 36° N. lat. and 350 lb (159 kg) south of 36° N. lat.). DTLs may not be accumulated or combined into a larger landing. North of 36° N. lat., DTL landings are also counted toward a 2-month cumulative limit of 2,700 lb (1,225 kg). South of 36° N. lat., a fisher may opt to make one landing per week above 350 lb (159 kg), but no more than 1,050 lb (476 kg).

For commercial fisheries, direct targeting and opportunities to take overfished species as bycatch are severely curtailed. Fixed gear generally has greater access than trawl gear to rockfish living on and around high relief rockpiles. To prevent commercial fixed gear vessels from fishing for nearshore rockfish, shelf rockfish, and lingcod during periods when the recreational fisheries for those species are closed, the Council recommended also closing commercial fixed gear fishing for those species during the same areas and periods. All limited entry fixed gear (pot and longline) vessels south of 40°10' N. lat. are prohibited from fishing for nearshore rockfish, shelf rockfish, and

lingcod, with allowances for vessels fishing inside of the 20-fathom (36.9 m) depth contour. (In January and February south of 34°27' N. lat., closed except for minor nearshore rockfish inside 20 fathoms (36.9 m); in March and April between 40°10' N. lat. to 34°27' N. lat., closed; in May and June between 40°10' N. lat. to 34°27' N. lat., closed except for minor nearshore rockfish inside 20 fathoms (36.9 m)). Concurrent commercial and recreational closures are expected to achieve conservation goals while reducing the conflict that sometimes occurs when one gear type is allowed to fish while the other gear type is not. The Council expects that these commercial closures will also reduce the chance that a commercial vessel could take advantage of the recreational closure to target known rockfish hotspots available only to nontrawl gear.

Open Access (Hook-and-Line, Troll, Pot, Setnet, Trammel Net)

The open access nontrawl fishery is managed separately from the limited entry fixed-gear fishery. As in the past, open access cumulative trip limits continue to be applied mostly to 1-month periods, and thornyheads may not be taken and retained north of 36° N. lat. Time and area closures are used south of 40°10' N. lat., similar to the limited entry fixed gear fisheries and for the same reasons. Vessels participating in the open access fisheries with nontrawl gear (hook-and-line, troll, pot, setnet and trammel net) south of 40°10' N. lat. are prohibited from fishing for nearshore rockfish, shelf rockfish, and lingcod, with allowances for vessels fishing inside of the 20-fathom (36.9m) depth contour. (In January and February south of 34°27' N. lat., closed except for minor nearshore rockfish inside 20 fathoms (36.9 m); in March and April between 40°10' N. lat. to 34°27' N. lat., closed; in May and June between 40°10' N. lat. to 34°27' N. lat., closed except for minor nearshore rockfish inside 20 fathoms (36.9 m)). The lingcod fishery for all open access nontrawl gears is also subject to the same closure, size limits, and cumulative trip limits as limited entry fixed gear fisheries. As in 2000, the Council wanted to provide a continued opportunity to nearshore fishers to selectively harvest black and blue rockfish north of 40°10' N. lat., while discouraging excessive harvest of other nearshore species. Consequently, the cumulative trip limit provides for landings of 3,000 lb (1,361 kg) per 2 months of nearshore rockfish, of which no more than 900 lb (408 kg) may be species other than black or blue rockfish. Cowcod prohibitions and closures apply to all open access vessels.

In 1998 and prior years, most open access limits were linked to (and could not exceed) limited entry limits, so that the open access monthly cumulative limits for most species were 50 percent of the limited entry 2-month cumulative limits for those species. Since 1999, open access cumulative limits have not been linked to limited entry cumulative limits. Open access cumulative limits may exceed those for limited entry. If a vessel with a limited entry permit uses open access gear (including exempted trawl gear) and the open access cumulative limit is larger, the vessel will be constrained by the smaller, limited entry cumulative limit for the entire cumulative period.

Open Access Exempted Trawl Gear

Open access exempted trawl gear (used to harvest spot and ridgeback prawns, California halibut, sea cucumbers, or pink shrimp) is managed with both ''per trip'' limits and cumulative trip limits. These trip limits are similar to those in 2000, and the species-specific open access limits apply but may not exceed the overall groundfish limits. The limits are 500 lb (227 kg) of groundfish per day, not to exceed 1,500 lb (680 kg) per trip in the pink shrimp fishery. For other exempted trawl gears, there is a 300-lb (136-kg) per trip limit. The pink shrimp fishery is subject to species-specific limits that are different from other open access limits for lingcod, canary rockfish, and sablefish. Cowcod prohibitions and closures apply to all open access vessels.

Recreational Fishery

Recreational fisheries are also restricted for conservation reasons, particularly for lingcod, canary rockfish, and bocaccio, which have significant recreational catches. Washington, Oregon, and California each proposed, and the Council recommended, different combinations of seasons, bag limits and size limits to best fit the needs of their recreational fisheries, while meeting the conservation goals.

For lingcod, Washington closed the recreational fishery for 5 months (January 1–March 15, October 15–December 31) and raised the bag limit from 1 to 2 fish, while maintaining the 24-inch (61 cm) minimum size limit. Oregon lowered its bag limit from 2 to 1 lingcod and maintained its 24-inch (61-cm) size limit, but removed its 34-inch (86-cm) maximum size limit. California maintained its 2 lingcod bag limit, and a minimum size limit of 26 inches (66 cm), and closed the lingcod season January-February south of 34°27' N. lat. and March-June from 40°10' N. lat. to 34°27' N. lat. As recently as 1998, all three states had 3-fish lingcod bag limits and year-round seasons for this species. Recreational fisheries measures are more liberal off Washington State and somewhat revised in Oregon because of the slightly higher lingcod OY in 2001. California fisheries in 2000 achieved the bulk of the recreational lingcod allocation and had to be curtailed late in the year to prevent the fishery from exceeding the recreational lingcod allocation in 2001.

To prevent overfishing and rebuild overfished rockfish, the states took a number of additional actions. Washington maintained its 10 rockfish bag limit, but added that no more than 2 rockfish could be either canary rockfish or yelloweye rockfish, a species on which overfishing occurred in 1999. (Yelloweye are not common in trawl catches.) Oregon maintained its 10 rockfish bag limit, of which no more than 1 may be canary rockfish, a reduction from 3 canary rockfish in 2000. California maintained its 10 rockfish bag limit, reduced its canary rockfish sublimit from 3 fish to 1 fish, and also reduced its bocaccio sublimit from 3 fish to 2 fish, and kept its 10-inch (25-cm) minimum size limit for bocaccio. California also reduced its hook-per-pole limit from 3 hooks to 2 hooks. For bocaccio, the 10-inch (25-cm) minimum size off California was adopted to discourage the targeting of young fish off piers and jetties. Bocaccio smaller than 10 inches (25 cm) are common in shallow water during their first year of life, before they have an opportunity to mature and spawn. Fish caught off piers and jetties do not suffer from decompression and are expected to have high survive if returned quickly to sea.

To assist in species identification off California, the entire skin must remain on rockfish filets. This requirement provides a more effective means of enforcing reductions in bag limits for rockfish, in general, and for bocaccio, cowcod, and canary rockfish, in particular, because it is difficult to accurately distinguish among rockfish species unless the entire skin is attached.

Size limits are imposed on the following three species to protect young fish in nearshore waters off California: cabezon, 15-inch (38-cm) size limit; kelp greenling, 12-inch (30-cm) size limit; and California scorpionfish (also called ≥sculpin≥), 10- inch (25-cm) size limit. These recreational size limits apply to species with a conservation need that are of commercial and recreational

importance. Furthermore, these species are harvested in waters that are shallow enough to ensure a high likelihood of survival following capture and release. For cabezon, greenling, and California scorpionfish, the minimum size limits are intended to provide at least 50 percent of adult females of each species with an opportunity to spawn at least once. California state law subjects commercial fisheries off California to the same size limits for these three species.

Different season closures were chosen north and south of Point Conception in order to maximize benefits to bocaccio and canary rebuilding, while limiting disruption to the overall recreational fishery to 2-month or 4-month periods. Season closures were chosen to correspond with the periods of greatest benefit statewide for bocaccio and canary rockfish. Historically, over 40 percent of annual recreational landings of bocaccio in southern California have occurred during January and February, so prohibiting most rockfish landings during those months has the highest potential benefit for bocaccio. Nearly all canary rockfish catches in California have occurred north of Point Conception, where about 39 percent of the catch occurs during March-June, which is the greatest proportion of the total annual catch taken in any four consecutive months. March-June also accounts for a comparatively high proportion of the bocaccio catch north of Point Conception.

Season closures allow for modestly higher trip and bag limits than otherwise would be possible under year-round fishing. Season closures are also expected to result in fewer discards than otherwise would occur. Concurrent seasons for recreational and commercial nontrawl fisheries are more cost effective to enforce than staggered seasons and minimize conflicts between commercial nontrawl and recreational fishers who fish for nearshore and shelf rockfish.

Additional reductions in bocaccio and canary rockfish landings will be realized from lowering the daily bag limits for those species in the recreational fishery. Changing the daily bag limit for bocaccio from three fish to two fish may reduce recreational bocaccio landings between 12 and 23 percent. Likewise, lowering the daily bag limit for canary rockfish from three fish to one fish is expected to reduce recreational landings of canary rockfish by about 36 percent.

The most dramatic change to recreational fisheries management for groundfish is the introduction of the CCAs and the prohibition on cowcod retention. Cowcod has been an attractive target fish for recreational anglers because of its rare occurrence and because it is one of the largest rockfishes (up to 37 inches (95 cm) in length). Council recommendations for cowcod harvest are intended to emphasize that cowcod are rare because they have been overfished, and that anglers need to avoid cowcod rather than pursue them. Recreational fisheries are subject to the same cowcod prohibitions and closures as commercial fisheries.

Fishing Communities and Impacts

The Magnuson-Stevens Act requires that actions taken to implement FMPs be consistent with the 10 national standards, one of which requires that conservation and management measures ''take into account the importance of fishery resources to fishing communities in order to (A) provide for the sustained participation of such communities and (B), to the extent practicable, minimize adverse economic impacts on such communities.'' Commercial and recreational fisheries for Pacific coast groundfish contribute to the economies and shape the cultures of numerous fishing communities in Washington, Oregon, and California. Meeting the needs of fishing communities has become increasingly difficult because the Council manages a fishery that is overcapitalized and contains stocks that are overfished. In setting this year's specifications and management measures, the Council took several steps to accommodate the needs of those communities within the constraints of Magnuson-Stevens Act requirements to rebuild overfished stocks and to prevent overfishing. In general, the Council allows the largest harvest possible, consistent with conservation needs of the fish stocks.

For three of the five overfished species (lingcod, bocaccio, and canary rockfish), the Council could have prohibited all landings of these species, despite knowing that these three species are caught in mixed-stock fisheries. Interception and incidental mortality for these stocks are inevitable whether a retention prohibition is in place or not. Instead, the Council looked for some minimum level of retention in both commercial and recreational fisheries that would allow fishery participants to land some of their incidental catch of those species. The Council's goal was to set retention at some minimal level that would discourage targeting, while allowing fishers to land already-dead, incidentally caught fish. The retention levels allowed for each of these species are below the overfishing level and allow rebuilding, but also account for some unintentional catch.

In addition to measures that cushion the socio-economic effects of rebuilding, the Council continued the year-round fishery opportunity that is important to the fishing and processing sectors for maintaining a continuity of employment. The Council modified the cumulative trip limit system that has been used in recent years to extend the fishing season throughout the year by providing opportunities for at least some groundfish species and by maintaining trawl gear restrictions initially adopted for 2000. These gear restrictions use operational and economic incentives to prevent bottom trawl fishing with roller gear for some species and encourage use of midwater trawl and small footrope trawls on the continental shelf where most overfished species occur. These strategies were first developed for the 2000 fishery by a group of industry participants who met with the Groundfish Management Team (GMT) about achieving conservation goals while minimizing effects on the industry and coastal communities. Offering higher limits to gear with lower bycatch rates reduces bycatch and enhances economic opportunities by providing access to healthy stocks.

Nonetheless, the effects of these 2001 management measures on some fishers and communities will be severe, particularly for those without other opportunities. For the 2001 fishery, the Council proposed stringent harvest levels intended to protect and rebuild overfished and depleted stocks. In addition to reducing OYs for overfished stocks, the Council also severely constrained harvest on healthy stocks associated with those overfished stocks. These measures were needed to ensure that rebuilding of overfished and depleted stocks could occur. However, they will cause serious socio-economic repercussions as a result of these lower harvest levels and the consequent lower landings limits.

On January 19, 2000, Commerce Secretary William Daley announced that the West Coast groundfish fishery qualified as a ''fishery failure'' under the Magnuson-Stevens Act. NMFS had determined that this ''fishery failure'' was the result of several factors, primarily a long period of low ocean productivity combined with incorrect assumptions about the productivity of groundfish stocks. As discussed earlier in the section on the Council's new and more conservative harvest policy, recent scientific studies have shown that West Coast groundfish stocks have relatively low productivity when compared to other, similar stocks throughout the world. Thus, the Council had to conservatively adjusted its current

harvest policies to account for this new information about lower groundfish productivity, and set lower harvest limits to rebuild stocks that had been inadvertently fished at overly aggressive rates in the past.

In addressing the economic side of the fishery failure, NMFS estimated that implementing 2000 OYs and landings limits would result in about a 25 percent loss ($9-11 million) in revenue for the industry, as compared to 1999 OYs and landings levels. Groundfish harvest is even more constrained for 2001 with the implementation of the canary rockfish rebuilding plan. Participation in the groundfish fishery, particularly for open access fishers, has declined over the past several years. In 1994, approximately 1,900 vessels landed groundfish in the open access fishery coastwide. In 1999, approximately 1,500 open access vessels landed groundfish in 1999. Out of the 400 vessels leaving the fishery, approximately 300 had participated in the fishery south of Cape Mendocino, CA. Participation in the open access fishery is more flexible than participation in the limited entry fishery; open access vessels are more likely to move between fisheries from year to year, or to try a new economic venture altogether. Thus, open access fleet size may be used as a gauge of the overall economic viability of the fishery.

Distribution of the economic effect of the 2001 management measures will depend on how well the fishers can adapt to the restrictions. Some user groups, particularly those able to use midwater trawl gear, will have a greater opportunity to harvest than they would have had without gear restrictions, because the Council recommended restrictions that encourage fishers to use gear that reduces incidental catch of the depleted rockfish. Other fishers will not be able to maintain a viable operation at the reduced harvest levels. The Council prepared an EA/RIR for this action, which includes a discussion of the economic and social effects of these management measures on coastal communities (see **ADDRESSES**).

Summary of Management Changes in 2001

Section IV below incorporates the regulatory text that applies to fishers operating in the Pacific coast groundfish fishery in 2001. Many provisions are the same as in 2000, but a number of revisions and format changes have been made. New cumulative trip limit periods are announced at IV.A.(1)(c) that apply to both limited entry and open access fisheries. Explanations of size limit measurements and weight conversions are found at paragraph IV.A.(6), including a new filet length description for recreational fisheries. The sablefish size limit for trawlers and the limited entry, fixed-gear regular and mop-up sablefish fisheries have been eliminated. Paragraph IV.A. (11) clarifies how cumulative trip limits are applied for a limited entry vessel operating in the open access fishery if the open access limit is larger than the limited entry limit. Paragraph IV.A.(12) on ''crossover'' provisions includes new discussions of how crossover provisions apply to minor rockfish species and how they apply to the DTS complex for limited entry trawlers. Paragraph IV.A.(13) includes a list of species that must be sorted. Gear restrictions for the limited entry fishery appear in paragraph IV.A.(14); cumulative trip limits differ for many species depending on the type of trawl gear used. The first days of the major cumulative limit periods, which establish when limited entry permit transfers must be completed, are announced in paragraph IV.A.(15). Platooning dates for the year 2000 are listed in paragraph IV.A.(16). A new paragraph IV.A.(20) is inserted to define the CCAs. Classifications of nearshore, shelf, and slope rockfish are found at paragraph IV.A.(21), and minor rockfish species are listed in Table 2.

Cumulative trip limits are set into tables, with explanations in Section IV. However, the industry is cautioned not to rely on the tables alone. The text in Section IV provides cumulative trip limit definitions and periods, size limit definitions and conversions, and other information that cannot be readily included in a table but must be understood in order to correctly use the tables. The sablefish allocations and nontrawl sablefish management, Pacific whiting allocations and seasons, and ''per trip'' limits for black rockfish off Washington State are still presented in text in paragraphs IV.B. Discussions of trip limits for exempted trawl gear in the open access fishery (paragraph IV.C.), recreational management measures (paragraph IV.D.), and tribal allocations and management measures (paragraph V.) still remain in the text.

How to Use the Trip Limit Tables

Cumulative trip limits are applied during the time periods and in the areas indicated in Tables 3-5 of Section IV. The cumulative trip limit may be taken at any time within the applicable cumulative trip limit period. All cumulative trip limit periods start at 0001 hours, local time, on the specified beginning date, except for ≥B≥ platoon trawl vessels whose limits start on the 16th of the month (see paragraph IV.A.(16).

Example 1: Line 2 of Table 3 for the limited entry trawl fishery means: North of 40°10' N. lat., the cumulative trip limit for minor slope rockfish is 1,500 lb (680 kg) per 2-month period; the 2-month periods are January 1-February 28 and March 1-April 30.

Example 2: The trip limits for bocaccio on Table 4 for limited entry fixed gear mean: From January 1 through February 28, the trip limit for bocaccio between 40°10' N. lat. and 34°27' N. lat. is 300 lb (136 kg) each month. However, the fishery for bocaccio is closed from March 1 to April 30, which means bocaccio may not be taken, retained, possessed or landed between 40°10' N. lat. and 34°27' N. lat. during that time period. The cumulative trip limit increases to 500 lb (227 kg) per month on May 1, but a fisher may not fish ahead on that amount (see paragraph IV.A.(2)). Bocaccio taken and retained north of 40°10' N. lat. are not explicitly mentioned in the table, which means they are included in the trip limit for ''minor shelf rockfish-north'' (see footnote 5 of Table 4).

IV. NMFS Actions

For the reasons stated above, the Assistant Administrator for Fisheries, NOAA (Assistant Administrator), concurs with the Council's recommendations and announces the following management actions for 2001, including both measures that are unchanged from 2000 and new measures.

A. General Definitions and Provisions

The following definitions and provisions apply to the 2001 management measures, unless otherwise specified in a subsequent **Federal Register** document:

(1) *Trip limits*. Trip limits are used in the commercial fishery to specify the amount of fish that may legally be taken and retained, possessed, or landed, per vessel, per fishing trip, or cumulatively per unit of time, or the number of landings that may be made from a vessel in a given period of time, as follows:

(a) A ''per trip'' limit is the total allowable amount of a groundfish species or species group, by weight, or by percentage of weight of legal fish on board, that may be taken and retained, possessed, or landed per vessel from a single fishing trip.

(b) A daily trip limit is the maximum amount that may be taken and retained, possessed, or landed per vessel in 24 consecutive hours, starting at 0001 hours l.t. Only one landing of groundfish may be made in that 24-hour

period. Daily trip limits may not be accumulated during multiple day trips.

(c) A cumulative trip limit is the maximum amount that may be taken and retained, possessed, or landed per vessel in a specified period of time without a limit on the number of landings or trips, unless otherwise specified. The cumulative trip limit periods for limited entry and open access fisheries, which start at 0001 hours l.t. and end at 2400 hours l.t., are as follows, unless otherwise specified:

(i) The 2-month periods are: January 1-February 28, March 1-April 30, May 1-June 30, July 1-August 31, September 1-October 31, and, November 1-December 31.

(ii) One month means the first day through the last day of the calendar month.

(iii) One week means 7 consecutive days, Sunday through Saturday.

(2) *Fishing ahead.* Unless the fishery is closed, a vessel that has landed its cumulative or daily limit may continue to fish on the limit for the next legal period, so long as no fish (including, but not limited to, groundfish with no trip limits, shrimp, prawns, or other nongroundfish species or shellfish) are landed (offloaded) until the next legal period. As stated at 50 CFR 660.302 (in the definition of ''landing''), once the offloading of any species begins, all fish aboard the vessel are counted as part of the landing. Fishing ahead is not allowed during or before a closed period (see paragraph IV.A.(7)). See paragraph IV.A.(9) for information on inseason changes to limits.

(3) *Weights.* All weights are round weights or round-weight equivalents unless otherwise specified.

(4) *Percentages.* Percentages are based on round weights, and, unless otherwise specified, apply only to legal fish on board.

(5) *Legal fish.* ''Legal fish'' means fish legally taken and retained, possessed, or landed in accordance with the provisions of 50 CFR part 660, the Magnuson-Stevens Act, any document issued under part 660, and any other regulation promulgated or permit issued under the Magnuson-Stevens Act.

(6) *Size limits and length measurement.* Unless otherwise specified, size limits in the commercial and recreational groundfish fisheries apply to the ''total length'': the longest measurement of the fish without mutilation of the fish or the use of force to extend the length of the fish. No fish with a size limit may be retained if it is in such condition that its length has been extended or cannot be determined by these methods. For conversions not listed here, contact the state where the fish will be landed.

(a) *Whole fish.* For a whole fish, total length is measured from the tip of the snout (mouth closed) to the tip of the tail in a natural, relaxed position.

(b) *''Headed'' fish.* For a fish with the head removed (''headed''), the length is measured from the origin of the first dorsal fin (where the front dorsal fin meets the dorsal surface of the body closest to the head) to the tip of the upper lobe of the tail; the dorsal fin and tail must be left intact.

(c) *Filets.* A filet is the flesh from one side of a fish extending from the head to the tail, which has been removed from the body (head, tail, and backbone) in a single continuous piece. Filet lengths may be subject to size limits for some groundfish taken in the recreational fishery off California (see paragraph IV. D.(1)). A filet is measured along the length of the longest part of the filet in a relaxed position; stretching or otherwise manipulating the filet to increase its length is not permitted.

(d) *Sablefish weight limit conversions.* The following conversions apply to both the limited entry and open access fisheries when trip limits are effective for those fisheries. For headed and gutted (eviscerated) sablefish, the conversion factor established by the state where the fish is or will be landed will be used to convert the processed weight to round weight for purposes of applying the trip limit. (The conversion factor currently is 1.6 in Washington, Oregon, and California. However, the state conversion factors may differ; fishers should contact fishery enforcement officials in the state where the fish will be landed to determine that state's official conversion factor.)

(e) *Lingcod size and weight conversions.* The following conversions apply in both limited entry and open access fisheries.

(i) *Size conversion.* For lingcod with the head removed, the minimum size limit is 19.5 inches (49.5 cm), which corresponds to 24 inches (61 cm) total length for whole fish.

(ii) *Weight conversion.* The conversion factor established by the state where the fish is or will be landed will be used to convert the processed weight to round weight for purposes of applying the trip limit. (The states' conversion factors may differ, and fishers should contact fishery enforcement officials in the state where the fish will be landed to determine that state's official conversion factor.) If a state does not have a conversion factor for headed and gutted lingcod, or lingcod that is only gutted; the following conversion factors will be used. To determin (A) *Headed and gutted.* The conversion factor for headed and gutted lingcod is 1.5. e the round weight, multiply the processed weight times the conversion factor.

(B) *Gutted, with the head on.* The conversion factor for lingcod that has only been gutted is 1.1.

(7) *Closure.* ''Closure,'' when referring to closure of a fishery, means that taking and retaining, possessing, or landing the particular species or species group is prohibited.(See 50 CFR 660.302.) Unless otherwise announced in the Federal Register, offloading must begin before the time the fishery closes. [Note: Special provisions are made for an at-sea closure at the end of the regular season for the sablefish limited entry fishery. See 50 CFR 660.323(a)(2).] The provisions at paragraph IV.A.(2) for fishing ahead do not apply during a closed period. It is unlawful to transit through a closed area with the prohibited species on board, no matter where that species was caught, except as provided for in the CCA at IV. A.(20).

(8) *Fishery management area.* The fishery management area for these species is the EEZ off the coasts of Washington, Oregon, and California between 3 and 200 nm offshore, bounded on the north by the Provisional International Boundary between the United States and Canada, and bounded on the south by the International Boundary between the United States and Mexico. All groundfish possessed between 0-200 nm offshore or landed in Washington, Oregon, or California are presumed to have been taken and retained from the EEZ, unless otherwise demonstrated by the person in possession of those fish.

(9) *Routine management measures.* Most trip, bag, and size limits in the groundfish fishery have been designated ''routine '', which means they may be changed rapidly after a single Council meeting. (See 50 CFR 660.323(b).) Council meetings in 2001 will be held in the months of March, April, June, September, and November. Inseason changes to routine management measures are announced in the **Federal Register**. Information concerning changes to routine management measures is available from the NMFS Northwest and Southwest Regional Offices (see **ADDRESSES**). Changes to trip limits are effective at the times stated in the **Federal Register**. Once a change is effective, it is illegal to take and retain, possess, or land more fish than allowed under the new trip limit. This means that, unless otherwise announced in the **Federal Register**, offloading must begin before the time a fishery closes or a more restrictive trip limit takes effect.

(10) *Limited entry limits*. It is unlawful for any person to take and retain, possess, or land groundfish in excess of the landing limit for the open access fishery without having a valid limited entry permit for the vessel affixed with a gear endorsement for the gear used to catch the fish (50 CFR 660.306(p)).

(11) *Operating in both limited entry and open access fisheries*. The open access trip limit applies to any fishing conducted with open access gear, even if the vessel has a valid limited entry permit with an endorsement for another type of gear. A vessel that operates in both the open access and limited entry fisheries is not entitled to two separate trip limits for the same species. If a vessel has a limited entry permit and uses open access gear, but the open access limit is smaller than the limited entry limit, the open access limit cannot be exceeded and counts toward the limited entry limit. If a vessel has a limited entry permit and uses open access gear, but the open access limit is larger than the limited entry limit, the smaller limited entry limit applies, even if taken entirely with open access gear.

(12) *Operating in areas with different trip limits*. Trip limits for a species or a species group may differ in different geographic areas along the coast. The following ''crossover'' provisions apply to vessels operating in different geographical areas that have different cumulative or ''per trip'' trip limits for the same species or species group. Such crossover provisions do not apply to species that are subject only to daily trip limits, or to the trip limits for black rockfish off Washington (see 50 CFR 660.323(a)(1)). In 2001, the cumulative trip limit periods for the limited entry and open access fisheries are specified in paragraph IV.A(1)(c), but may be changed during the year if announced in the **Federal Register**.

(a) *Going from a more restrictive to a more liberal area*. If a vessel takes and retains any groundfish species or species group of groundfish in an area where a more restrictive trip limit applies before fishing in an area where a more liberal trip limit (or no trip limit) applies, then that vessel is subject to the more restrictive trip limit for the entire period to which that trip limit applies, no matter where the fish are taken and retained, possessed, or landed.

(b) *Going from a more liberal to a more restrictive area*. If a vessel takes and retains a groundfish species or species group in an area where a higher trip limit or no trip limit applies, and takes and retains, possesses or lands the same species or species group in an area where a more restrictive trip limit applies, that vessel is subject to the more restrictive trip limit for the entire period to which that trip limit applies, no matter where the fish are taken and retained, possessed, or landed.

(c) *Minor rockfish*. Several rockfish species are designated with species-specific limits on one side of the 40°10 N. lat. management line, and are included as part of a minor rockfish complex on the other side of the line.

(i) If a vessel takes and retains minor slope rockfish north of 40°10' N. lat., that vessel is also permitted to take and retain, possess or land splitnose rockfish up to its cumulative limit south of of 40°10' N. lat., even if splitnose rockfish were a part of the landings from minor slope rockfish taken and retained north of 40°10 N. lat. [Note: A vessel that takes and retains minor slope rockfish on both sides of the management line in a single cumulative limit period is subject to the more restrictive cumulative limit for minor slope rockfish during that period.]

(ii) If a vessel takes and retains minor shelf rockfish north of 40°10' N. lat., that vessel is also permitted to take and retain, possess, or land chilipepper rockfish and bocaccio up to their respective cumulative limits south of 40°10' N. lat., even if either species is part of the landings from minor shelf rockfish taken and retained north of 40°10' N. lat. [Note: A vessel that takes and retains minor shelf rockfish on both sides of the management line in a single cumulative limit period is subject to the more restrictive cumulative limit for minor shelf rockfish during that period.]

(iii) If a vessel takes and retains minor shelf rockfish south of 40°10' N. lat., that vessel is also permitted to take and retain, possess, or land yellowtail rockfish and POP up to their respective cumulative limits north of 40°10' N. lat., even if either species is part of the landings from minor shelf rockfish taken and retained south of 40°10' N. lat. [Note: A vessel that takes and retains minor shelf rockfish on both sides of the management line in a single cumulative limit period is subject to the more restrictive cumulative limit for minor shelf rockfish during that period.]

(d) ''*DTS complex*.'' For 2001, differential trip limits are introduced for the ''DTS complex'' (Dover sole, shortspine thornyhead, longspine thornyhead, sablefish) north and south of the management line at 40°10' N. lat. Vessels operating in the limited entry trawl fishery are subject to the crossover provisions in this paragraph IV.A.(12) when making landings that include any one of the four species in the ''DTS complex.'' [Example: The January-February cumulative limit for Dover sole north of 40°10' N. lat. is 65,000 lb (29,484 kg) and the cumulative limit for sablefish in that same period and area is 5,000 lb (2,268 kg), while the cumulative limits south of 40°10' N. lat. are 35,000 lb (15,876 kg) for Dover sole and 8,000 lb (3,629 kg) for sablefish. Under the crossover provisions, a vessel may not take and retain Dover sole north of 40°10' N. lat. and then travel south of 40°10' N. lat. in that same 2-month period to take and retain the higher sablefish limit in the south.]

(13) *Sorting*. It is unlawful for any person to ''fail to sort, prior to the first weighing after offloading, those groundfish species or species groups for which there is a trip limit, size limit, quota, or commercial OY, if the vessel fished or landed in an area during a time when such trip limit, size limit, commercial optimum yield, or quota applied.'' This provision applies to both the limited entry and open access fisheries. (See 50 CFR 660.306(h).) The following species must be sorted in 2001:

(a) For vessels with a limited entry permit:

(i) Coastwide—widow rockfish, canary rockfish, darkblotched rockfish, minor nearshore rockfish, minor shelf rockfish, minor slope rockfish, shortspine and longspine thornyheads, Dover sole, arrowtooth flounder, rex sole, petrale sole, other flatfish, lingcod, sablefish, and Pacific whiting;

(ii) North of 40°10' N. lat.--Pacific ocean perch, yellowtail rockfish, and, for fixed gear, black rockfish and blue rockfish;

(iii) South of 40°10' N. lat.--chilipepper rockfish, bocaccio rockfish, splitnose rockfish.

(b) For open access vessels (vessels without a limited entry permit):

(i) Coastwide—widow rockfish, canary rockfish, darkblotched rockfish, minor nearshore rockfish, minor shelf rockfish, minor slope rockfish, arrowtooth flounder, other flatfish, lingcod, sablefish, and Pacific whiting;

(ii) North of 40°10' N. lat.—black rockfish, blue rockfish, Pacific ocean perch, yellowtail rockfish;

(iii) South of 40°10' N. lat.—chilipepper rockfish, bocaccio rockfish, splitnose rockfish;

(iv) South of Point Conception—thornyheads.

(14) *Limited Entry Trawl Gear Restrictions*. Limited entry trip limits may vary depending on the type of trawl gear that is on board a vessel during a fishing trip: large footrope, small footrope, or midwater trawl gear.

(a) *Types of trawl gear*—(i) Large footrope trawl gear is bottom trawl gear, as specified at 50 CFR 660.302 and

660.322(b), with a footrope diameter larger than 8 inches (20 cm) (including rollers, bobbins or other material encircling or tied along the length of the footrope).

(ii) Small footrope trawl gear is bottom trawl gear, as specified at 50 CFR 660.302 and 660.322(b), with a footrope diameter 8 inches (20 cm) or smaller (including rollers, bobbins or other material encircling or tied along the length of the footrope), except chafing gear may be used only on the last 50 meshes of a small footrope trawl, measured from the terminal (closed) end of the codend. Other lines or ropes that run parallel to the footrope may not be augmented or modified to violate footrope size restrictions.

(iii) Midwater trawl gear is pelagic trawl gear, as specified at 50 CFR 660.302 and 660.322(b)(2). The footrope of midwater trawl gear may not be enlarged by encircling it with chains or by any other means. Ropes or lines running parallel to the footrope of midwater trawl gear must be bare and may not be suspended with chains or other materials.

(b) *Cumulative trip limits and prohibitions*—(i) *Large footrope trawl.* It is unlawful to take and retain, possess or land any species of shelf or nearshore rockfish (defined at IV.A.(21) and Table 2 to Section IV) from a fishing trip if large footrope gear is onboard; this restriction applies coastwide from January 1 to December 31. North of 40°10' N. lat., it is unlawful to take and retain, possess or land petrale sole from a fishing trip if large footrope gear is onboard and the trip is conducted at least in part between May 1 and October 31; cumulative limits for ''all other flatfish'' (all flatfish except those with cumulative trip limits in Table 3 to Section IV) are lower for vessels with large footrope gear on board if the trip is conducted at least in part between May 1 and October 31. South of 40°10' N. lat., it is unlawful to take and retain, possess, or land petrale sole from a fishing trip if large footrope gear is on board and the trip is conducted at least in part during May 1-October 31; cumulative limits for arrowtooth flounder and ''all other flatfish'' are lower for vessels with large footrope gear on board if the trip is conducted at least in part between May 1 and October 31. (See Table 3). The presence of rollers or bobbins larger than 8 inches (20 cm) in diameter on board the vessel, even if not attached to a trawl, will be considered to mean a large footrope trawl is on board. Dates are adjusted for the ''B'' platoon (See IV.A.(16)).

(ii) *Small footrope or midwater trawl gear.* Cumulative trip limits for canary rockfish, widow rockfish, yellowtail rockfish, bocaccio, chilipepper, minor shelf rockfish, minor nearshore rockfish, and lingcod, as indicated in Table 3 to Section IV, are allowed only if small footrope gear or midwater trawl gear is used, and if that gear meets the specifications in paragraphs IV.A.(14).

(iii) *Midwater trawl gear.* Higher cumulative trip limits are available for limited entry vessels using midwater trawl gear to harvest widow, yellowtail, or chilipepper rockfish. Each landing that contains widow, yellowtail, or chilipepper rockfish is attributed to the gear on board with the most restrictive trip limit for those species. Landings attributed to small footrope trawl must not exceed the small footrope limit, and landings attributed to midwater trawl must not exceed the midwater trawl limit. If a vessel has landings attributed to both types of trawls during a cumulative trip limit period, landings attributed to small footrope gear are counted toward the cumulative limit for midwater trawl gear. [Example: The cumulative trip limit in January-February for widow rockfish is 20,000 lb (9,072 kg) per 2 month period, of which no more than 1,000 lb (454 kg) per month may be attributed to landings by small footrope trawl gear.]

(iv) *More than one type of trawl gear on board.* The cumulative trip limits in Table 3 of Section IV must not be exceeded. It is legal to have more than one type of limited entry trawl gear on board, but the most restrictive trip limit associated with the gear on board applies for that trip and will count toward the cumulative trip limit for that gear. [Example: If a vessel has large footrope gear on board, it cannot land chilipepper, even if the chilipepper is caught with a small footrope trawl. If a vessel has both small footrope trawl and midwater trawl gear onboard, the landing is attributed to the more restrictive small footrope trawl limit, even if midwater trawl gear was used.]

(c) *Measurement.* The footrope will be measured in a straight line from the outside edge to the opposite outside edge at the widest part on any individual part, including any individual disk, roller, bobbin, or any other device.

(d) *State landing receipts.* Washington, Oregon, and California will require the type of trawl gear on board with the most restrictive limit to be recorded on the State landing receipt(s) for each trip or an attachment to the State landing receipt.

(e) *Gear inspection.* All trawl gear and trawl gear components, including unattached rollers or bobbins, must be readily accessible and made available for inspection at the request of an authorized officer. No trawl gear may be removed from the vessel prior to offloading. All footropes shall be uncovered and clearly visible except when in use for fishing.

(15) *Permit transfers.* Limited entry permit transfers are to take effect only on the first day of a major cumulative limit period (50 CFR 660.333(c)(1)); those days in 2001 are January 1, March 1, May 1, July 1, September 1, and November 1, and are delayed by 15 days (starting on the 16th of a month) for the ''B'' platoon.

(16) *Platooning—limited entry trawl vessels.* Limited entry trawl vessels are automatically in the ≥A≥ platoon, unless the ≥B≥ platoon is indicated on the limited entry permit. If a vessel is in the ''A'' platoon, its cumulative trip limit periods begin and end on the beginning and end of a calendar month as in the past. If a limited entry trawl permit is authorized for the ''B'' platoon, then cumulative trip limit periods will begin on the 16th of the month (generally 2 weeks later than for the ''A'' platoon), unless otherwise specified.

(a) For a vessel in the ''B'' platoon, cumulative trip limit periods begin on the 16th of the month at 0001 hours, l.t., and end on the 15th of the month. Therefore, the management measures announced herein that are effective on January 1, 2001, for the ''A'' platoon will be effective on January 16, 2001, for the ''B'' platoon. The effective date of any inseason changes to the cumulative trip limits also will be delayed for 2 weeks for the ''B'' platoon, unless otherwise specified.

(b) A vessel authorized to operate in the ''B'' platoon may take and retain, but may not land, groundfish from January 1, 2001, through January 15, 2001.

(c) A vessel authorized to operate in the ''B'' platoon will have the same cumulative trip limits for the November 16, 2001, through December 31, 2001, period as a vessel operating in the ''A'' platoon has for the November 1, 2001, through December 31, 2001 period.

(17) *Exempted fisheries.* U.S. vessels operating under an exempted fishing permit issued under 50 CFR part 600 also are subject to these restrictions, unless otherwise provided in the permit.

(18) Paragraphs IV.B. and IV.C. pertain to the commercial groundfish fishery, but not to Washington coastal tribal fisheries, which are described in Section V. The provisions in paragraphs IV.B. and IV.C. that are not covered under the headings ''limited entry'' or ''open access'' apply to all vessels in the commercial fishery that take and retain groundfish, unless otherwise stated.

Paragraph IV.D. pertains to the recreational fishery.

(19) Commonly used geographic coordinates.

(a) Cape Falcon, OR—45°46' N. lat.

(b) Cape Lookout, OR—45°20'15'' N. lat.

(c) Cape Blanco, OR--42°50' N. lat.

(d) Cape Mendocino, CA—40°30' N. lat.

(e) North/South management line—40°10' N. lat.

(f) Point Arena, CA—38°57'30'' N. lat.

(g) Point Conception, CA—34°27' N. lat.

(h) International North Pacific Fisheries Commission (INPFC) subareas (for more precise coordinates for the Canadian and Mexican boundaries, see 50 CFR 660.304):

(i) Vancouver—U.S.-Canada border to 47°30' N. lat.

(ii) Columbia—47°30' to 43°00' N. lat.

(iii) Eureka—43°00' to 40°30' N. lat.

(iv) Monterey--40°30' to 36°00' N. lat.

(v) Conception—36°00' N. lat. to the U.S.-Mexico border.

(20) *Cowcod Conservation Areas.* Recreational and commercial fishing for groundfish is prohibited within the Cowcod Conservation Areas (CCAs), except that recreational and commercial fishing for minor nearshore rockfish is permitted in waters inside 20 fathoms (36.9 m). It is unlawful to take and retain, possess, or land groundfish inside the CCAs, except for nearshore rockfish taken in waters inside the 20-fathom (36.9 m)depth contour. Commercial fishing vessels may transit through the Western CCA with their gear stowed and groundfish on board only in a corridor through the Western CCA bounded on the north by the latitude line at 33°00'30≥ N. lat., and bounded on the south by the latitude line at 32°59'30''.

(i) The Western CCA is an area south of Point Conception that is bound by straight lines connecting all of the following points in the order listed:

33°50' N. lat., 119°30' W. long.;
33°50' N. lat., 118°50' W. long.;
32°20' N. lat., 118°50' W. long.;
32°20' N. lat., 119°30' W. long.;
33°00' N. lat., 119°30' W. long.;
33°00' N. lat., 119°50' W. long.;
33°30' N. lat., 119°50' W. long.;
33°50' N. lat., 119°30' W. long.

(ii) The Eastern CCA is a smaller area west of San Diego that is bound by straight lines connecting all of the following points in the order listed:

32°40' N. lat., 118°00' W. long.;
32°40' N. lat., 117°50' W. long.;
32°30' N. lat., 117°50' W. long.;
32°40' N. lat., 118°00' W. long.
32°40' N. lat., 118°00' W. long.;

(21) *Rockfish categories.* Rockfish (except thornyheads) are divided into categories north and south of 40°10' N. lat., depending on the depth where they most often are caught: nearshore, shelf, or slope. (The term '' *Sebastes complex*'' no longer is used. Scientific names appear in Table 2.) New trip limits have been established for ''minor rockfish'' species according to these categories (see Tables 2-5).

(a) Nearshore rockfish consists entirely of the minor rockfish species listed in Table 2.

(b) Shelf rockfish consists of canary rockfish, shortbelly rockfish, widow rockfish (*Sebastes entomelas*), yellowtail rockfish, bocaccio, chilipepper, cowcod, and the minor shelf rockfish species listed in Table 2.

(c) Slope rockfish consists of Pacific ocean perch, splitnose rockfish, darkblotched rockfish, and the minor slope rockfish species listed in Table 2.

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Table 2 – Minor Rockfish Species (excludes thornyheads)

North of 40°10' N. lat.	South of 40°10' N. lat.
NEARSHORE	
black, Sebastes melanops	black, Sebastes melanops
black and yellow, S. chrysolmelas	black and yellow, S. chrysolmelas
blue, S. mystinus	blue, S. mystinus
brown, S. auriculatus	brown, S. auriculatus
calico, S. dalli	calico, S. dalli
China, S. nebulosus	California scorpionfish, Scorpaena guttata
copper, S. caurinus	China, Sebastes nebulosus
gopher, S. carnatus	copper, S. caurinus
grass, S. rastrelliger	gopher, S. carnatus
kelp, S. atrovirens	grass, S. rastrelliger
olive, S. serranoides	kelp, S. atrovirens
quillback, S. maliger	olive, S. serranoides
treefish, S. serriceps	quillback, S. maliger
	treefish, S. serriceps
SHELF	
bronzespotted, S. gilli	bronzespotted, S. gilli
bocaccio, S. paucispinis	chameleon, S. phillipsi
chameleon, S. phillipsi	dwarf-red, S. rufianus
chilipepper, S. goodei	flag, S. rubrivinctus
cowcod, S. levis	freckled, S. lentiginosus
dwarf-red, S. rufianus	greenblotched, S. rosenblatti
flag, S. rubrivinctus	greenspotted, S. chlorostictus
freckled, S. lentiginosus	greenstriped, S. elongatus
greenblotched, S. rosenblatti	halfbanded, S. semicinctus
greenspotted, S. chlorostictus	honeycomb, S. umbrosus
greenstriped, S. elongatus	Mexican, S. macdonaldi
halfbanded, S. semicinctus	pink, S. eos
honeycomb, S. umbrosus	pinkrose, S. simulator
Mexican, S. macdonaldi	pygmy, S. wilsoni
pink, S. eos	redstriped, S. proriger
pinkrose, S. simulator	rosethorn, S. helvomaculatus
pygmy, S. wilsoni	rosy, S. rosaceus
redstriped, S. proriger	silvergrey, S. brevispinus
rosethorn, S. helvomaculatus	speckled, S. ovalis
rosy, S. rosaceus	squarespot, S. hopkinsi
silvergrey, S. brevispinis	starry, S. constellatus
speckled, S. ovalis	stripetail, S. saxicola
squarespot, S. hopkinsi	swordspine, S. ensifer
starry, S. constellatus	tiger, S. nigorcinctus
stripetail, S. saxicola	vermilion, S. miniatus
swordspine, S. ensifer	yelloweye, S. ruberrimus
tiger, S. nigorcinctus	yellowtail, S. flavidus
vermilion, S. miniatus	
yelloweye, S. ruberrimus	
SLOPE	
aurora, S. aurora	aurora, S. aurora
bank, S. rufus	bank, S. rufus
blackgill, S. melanostomus	blackgill, S. melanostomus
darkblotched, S. crameri	darkblotched, S. crameri
redbanded, S. babcocki	Pacific ocean perch (POP), S. alutus
rougheye, S. aleutianus	redbanded, S. babcocki
sharpchin, S. zacentrus	rougheye, S. aleutianus
shortraker, S. borealis	sharpchin, S. zacentrus
splitnose, S. diploproa	shortraker, S. borealis
yellowmouth, S. reedi	yellowmouth, S. reedi

Limited Entry Fishery

(1) General. Most species taken in limited entry fisheries will be managed with cumulative trip limits (see paragraph IV.A.(1)(c), size limits (see paragraph IV.A.(6)), and seasons (see paragraph IV.A. (7)). The trawl fishery has gear requirements and trip limits that differ by the type of trawl gear on board (see paragraph IV.A.(14)). For the first time in 2001, cowcod retention is prohibited in all fisheries and groundfish vessels operating south of Point Conception must adhere to CCA

restrictions (see paragraph IV.A. (20)). Most of the management measures for the limited entry fishery are listed above and in Tables 3 and 4, and may be changed during the year by announcement in the **Federal Register**. However, the management regimes for several fisheries (nontrawl sablefish, Pacific whiting, and black rockfish) do not neatly fit into these tables and are addressed immediately following Tables 3 and 4.

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Table 3. 2001 Trip Limits [1/] and Gear Requirements [2/] for Limited Entry Trawl Gear
Read Section IV.A. NMFS Actions before using this table.

line	Species/groups	JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG	SEP-OCT	NOV-DEC
1	**Minor slope rockfish**						
2	North	1,500 lb/ 2 months		1,500 lb/ 2 months			1,500 lb/ 2 months
3	South	14,000 lb/ 2 months		14,000 lb/ 2 months			14,000 lb/ 2 months
4	Splitnose - South	8,500 lb/ 2months		14,000 lb/ 2 months			4,000 lb/ 2 months
5	Pacific ocean perch[6/]	1,500 lb/ month		2,500 lb/ month			1,500 lb/ month
6	DTS complex - North						
7	Sablefish	5,000 lb/ 2 months		14,000 lb/ 2 months			5,000 lb/ 2 months
8	Longspine thornyhead	6,000 lb/ 2 months		6,000 lb/ 2 months			6,000 lb/ 2 months
9	Shortspine thornyhead	1,500 lb/ 2 months		1,500 lb/ 2 months			1,500 lb/ 2 months
10	Dover sole	65,000 lb/ 2 months		20,000 lb/ 2 months			20,000 lb/ 2 months
11	DTS complex - South						
12	Sablefish	8,000 lb/ 2 months		11,000 lb/ 2 months			8,000 lb/ 2 months
13	Longspine thornyhead	6,000 lb/ 2 months		6,000 lb/ 2 months			6,000 lb/ 2 months
14	Shortspine thornyhead	1,500 lb/ 2 months		1,500 lb/ 2 months			1,500 lb/ 2 months
15	Dover sole	35,000 lb/ 2 months		35,000 lb/ 2 months			35,000 lb/ 2 months
16	**Flatfish - North**						
17	Arrowtooth flounder	20,000 lb/ trip		Small footrope: 30,000 lb/ month for all flatfish except Dover sole. Large footrope: arrowtooth, 5,000 lb/trip; petrale sole, prohibited; rex sole, included in all other flatfish; all other flatfish, 1,000 lb/ trip.			20,000 lb/ trip
18	Petrale sole	No restriction					No restriction
19	Rex sole	No limit					No limit
20	All other flatfish [3/]	small footrope, no limit; large footrope, 1,000 lb/ trip					small footrope, no limit; large footrope, 1,000 lb/ trip
21	**Flatfish - South**						
22	Arrowtooth flounder	20,000 lb/ trip		small footrope, no limit; large footrope, 5,000 lb/ trip			20,000 lb/ trip
23	Petrale sole	No restriction		No limit (small footrope required)			No restriction
24	Rex sole	small footrope, no limit; large footrope, 1,000 lb/ trip					
25	All other flatfish [3/]	small footrope, no limit; large footrope, 1,000 lb/ trip					
26	**Whiting shoreside** [4/]	20,000 lb/ trip		Primary Season			20,000 lb/ trip
27	**Use of small footrope bottom trawl[5/] or midwater trawl required for landing all of the following species:**						
28	**Minor shelf rockfish**						
29	North	300 lb/ month		1,000 lb/ month			300 lb/ month
30	South	500 lb/ month		1,000 lb/ month			500 lb/ month
31	Canary rockfish	100 lb/ month		300 lb/ month			100 lb/ month
32	Widow rockfish						
33	mid-water trawl	20,000 lb/ 2 months		10,000 lb/ 2 months		20,000 lb/ 2 months	10,000 lb/ 2 months
34	small footrope trawl	1,000 lb/ month					
35	Yellowtail - North[6/]						
36	mid-water trawl	30,000 lb/ 2 months		15,000 lb/ 2 months			20,000 lb/ 2 months
37	small footrope trawl	Without flatfish, 1,500 lb/ month. As flatfish bycatch, per trip limit is the sum of 33% (by weight) of all flatfish except arrowtooth flounder, plus 10% (by weight) of arrowtooth flounder, not to exceed 2,500 lb/ trip and 20,000 lb/ 2 months.		Without flatfish, 1,500 lb/ month. As flatfish bycatch, per trip limit is the sum of 33% (by weight) of all flatfish except arrowtooth flounder, plus 10% (by weight) of arrowtooth flounder, not to exceed 7,500 lb/ trip and not to exceed 15,000 lb/ 2 months.			Without flatfish, 1,500 lb/ month. As flatfish bycatch, As flatfish bycatch, per trip limit is the sum of 33% (by weight) of all flatfish except arrowtooth flounder, plus 10% (by weight) of arrowtooth flounder, not to exceed 2,500 lb/ trip and 30,000 lb/ 2 months
38	**Bocaccio - South**[6/]	300 lb/ month		500 lb/ month			300 lb/ month
39	**Chilipepper - South**[6/]						
40	mid-water trawl	25,000 lb/ 2 months					
41	small footrope trawl	7,500 lb/ 2 months					
42	Cowcod	**Retention is Prohibited**					
43	**Minor nearshore rockfish**						
44	North	200 lb/ month					
45	South	200 lb/ month					
46	Lingcod[7/]	No retention		400 lb/ month			No retention

1/ Trip limits apply coastwide unless otherwise specified. "North" means 40°10' N. lat. To the U.S.-Canada border. "South" means 40°10' N. lat. To the U.S.-Mexico border. 40°10' N. lat is about 20 nm south of Cape Mendocino, CA.

2/ Gear requirements and prohibitions are explained at paragraph IV.A.(14)

3/ "Other" flatfish means all flatfish at 50 CFR 660.302 except those in this Table 3 with a trip limit.

4/ The whiting "per trip" limit in the Eureka area inside 100 fm is 10,000 lb/ trip throughout the year. See IV.B.(3)c). The 20,000 lb/ trip limit applices before and after the primary season.

5/ Small footrope trawl means a bottom trawl net with a footrope no larger than 8 inches (20 cm) in diameter. Midwater gear also may be used; the footrope must be bare. See paragraph IV.A. (14).

6/ Yellowtail rockfish and POP in the south, and bocaccio, and chilipepper rockfishes in the north are included in the trip limits for minor shelf rockfish in the appropriate area (Table 2).

7/ The size limit for lingcod is 24 inches (61 cm) total length.

To convert pounds to kilograms, divide by 2.20462, the number of pounds in one kilogram.

Table 4. 2001 Trip Limits[1/] for Limited Entry Fixed Gear
Read Section IV.A. NMFS Actions before using this table.

line	Species/groups	JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG	SEP-OCT	NOV-DEC
1	**Minor slope rockfish**						
2	North	1,500 lb/ 2 months		1,500 lb/ 2 months			1,500 lb/ 2 months
3	South	14,000 lb/ 2 months		14,000 lb/ 2 months			14,000 lb/ 2 months
4	**Splitnose - South**	8,500 lb/ 2months		14,000 lb/ 2 months			4,000 lb/ 2 months
5	**Pacific ocean perch 5/**	1,500 lb/ month		2,500 lb/ month			1,500 lb/ month
6	**Sablefish**						
7	North of 36° N. lat.	300 lb/ day, 2,700 lb/ 2 months					
8	South of 36° N. lat.	350 lb/ day, or 1 landing per week of up to 1,050 lb					
9	**Longspine thornyhead**	6,000 lb/ 2 months		6,000 lb/ 2 months			6,000 lb/ 2 months
10	**Shortspine thornyhead**	1,500 lb/ 2 months		1,500 lb/ 2 months			1,500 lb/ 2 months
11	**Dover sole**						
12	North	65,000 lb/ 2 months		20,000 lb/ 2 months			20,000 lb/ 2 months
13	South	35,000 lb/ 2 months		35,000 lb/ 2 months			35,000 lb/ 2 months
14	**Flatfish - North**						
15	Arrowtooth flounder	20,000 lb/ trip		30,000 lb/ month for all flatfish except Dover sole			20,000 lb/ trip
16	Petrale sole	No restriction					No restriction
17	Rex sole	No limit					No limit
18	All other flatfish 2/	No limit					No limit
19	**Flatfish - South**						
20	Arrowtooth flounder	20,000 lb/ trip		No limit			20,000 lb/ trip
21	Petrale sole	No limit					
22	Rex sole	No limit					
23	All other flatfish 2/	No limit					
24	**Whiting 3/**	20,000 lb/ trip		Primary Season			20,000 lb/ trip
25	**Minor shelf rockfish**						
26	North	300 lb/ month		1,000 lb/ month			300 lb/ month
27	South						
28	40°10' - 34°27' N. lat.	500 lb/ month	CLOSED 4/		1,000 lb/ month		500 lb/ month
29	South of 34°27' N. lat.	CLOSED 4/	500 lb/ month				
30	**Canary rockfish**						
31	North	100 lb/ month		300 lb/ month			100 lb/ month
32	South						
33	40°10' - 34°27' N. lat.	100 lb/ month	CLOSED 4/		300 lb/ month		100 lb/ month
34	South of 34°27' N. lat.	CLOSED 4/	100 lb/ month				
35	**Widow rockfish**						
36	North	3,000 lb/ month					
37	South						
38	40°10' - 34°27' N. lat.	3,000 lb/ month	CLOSED 4/		3,000 lb/ month		
39	South of 34°27' N. lat.	CLOSED 4/	3,000 lb/ month				
40	**Yellowtail - North 5/**	1,500 lb/ month					
41	**Bocaccio - South 5/**						
42	40°10' - 34°27' N. lat.	300 lb/ month	CLOSED 4/		500 lb/ month		300 lb/ month
43	South of 34°27' N. lat.	CLOSED 4/	300 lb/ month				
44	**Chilipepper - South 5/**						
45	40°10' - 34°27' N. lat.	2,500 lb/ month	CLOSED 4/		2,500 lb/ month		
46	South of 34°27' N. lat.	CLOSED 4/	2,500 lb/ month				
47	**Cowcod**	CLOSED 4/ -- All Retention is Prohibited					
48	**Minor nearshore rockfish**						
49	North	10,000 lb/ 2 months, no more than 4,000 lb of which may be species other than black or blue rockfish 6/					
50	South						
51	40°10' - 34°27' N. lat.	2,000 lb/ 2 months	CLOSED 4/	Shoreward of 20 fm depth: 2,000 lb/ 2 months, otherwise CLOSED 4/	2,000 lb/ 2 months		
52	South of 34°27' N. lat.	Shoreward of 20 fm depth: 2,000 lb/ 2 months, otherwise CLOSED 4/	2,000 lb/ 2 months				
53	**Lingcod 7/**						
54	North	CLOSED 4/		400 lb/ month			CLOSED 4/
55	South						
56	40°10' - 34°27' N. lat.	CLOSED 4/			400 lb/ month		CLOSED 4/
57	South of 34°27' N. lat.	CLOSED 4/		400 lb/ month			CLOSED 4/

1/ Trip limits apply coastwide unless otherwise specified. "North" means 40°10' N. lat. To the U.S.-Canada border. "South" means 40°10' N. lat. To the U.S.-Mexico border. 40°10' N. lat is about 20 nm south of Cape Mendocino, CA.

2/ "Other flatfish" means all flatfish at 50 CFR 660.302 except those in this Table 4 with a trip limit.

3/ The whiting "per trip" limit in the Eureka area inside 100 fm is 10,000 lb/ trip throughout the year. See IV.B.(3)c).

4/ Closed means that it is prohibited to take and retain, possess, or land the designated species in the time or area indicated. See IV.A.(7). in the time or area indicated. See IV.A.(7).

5/ Yellowtail rockfish and POP in the south, and bocaccio, and chilipepper rockfishes in the north are included in the trip limits for minor shelf rockfish in the appropriate area (Table 2).

6/ The "per trip limit for black rockfish off Washington also applies. See paragraph IV.B.(4).

7/ The size limit for lingcod is 24 inches (61 cm) in the north, and 26 inches (66 cm) in the south, total length.

To convert pounds to kilograms, divide by 2.20462, the number of pounds in one kilogram.

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(2) *Sablefish*. The limited entry sablefish allocation is further allocated 58 percent to trawl gear and 42 percent to nontrawl gear. See footnote e/ of Table 1a.

(a) *Trawl trip and size limits*. Management measures for the limited entry trawl fishery for sablefish are listed in Table 3.

(b) *Nontrawl trip and size limits*. To take, retain, possess, or land sablefish during the regular or mop-up season for the nontrawl limited entry sablefish fishery, the owner of a vessel must hold a limited entry permit for that vessel, affixed with both a gear endorsement for longline or trap (or pot) gear, and a sablefish endorsement. (See 50 CFR 663.23(a)(2)(i).) A sablefish endorsement is not required to participate in the limited entry daily trip limit fishery.

(i) *Regular and mop-up seasons*. Starting and ending dates for the regular and mop-up seasons, and the size of the cumulative trip limits for the regular and mop-up seasons (see 50 CFR 660.323(a)(2)) will be announced later in the year.

(ii) *Daily trip limit*. The daily trip limit, which is listed in Table 4 and which applies to sablefish of any size, is in effect north of 36° N. lat. until the closed periods before or after the regular season as specified at 50 CFR 660.323(a)(2), between the end of the regular season and the beginning of the mop-up season, and after the mop-up season. The daily trip limit for sablefish taken and retained with nontrawl gear south of 36° N. lat. also is listed in Table 4, and continues throughout the year unless otherwise announced in the **Federal Register** because the regular and mop-up seasons do not apply south of 36° N. lat.

(3) *Whiting*. Additional regulations that apply to the whiting fishery are found at 50 CFR 660.306 and at 50 CFR 660.323(a)(3) and (a)(4).

(a) *Allocations*. The nontribal allocations are HGs, based on percentages that are applied to the commercial OY of 162,900 mt in 2001 (see 50 CFR 660.323(a)(4)), as follows:

(i) *Catcher/processor sector*--55,386 mt (34 percent);

(ii) *Mothership sector*--39,096 mt (24 percent);

(iii) *Shore-based sector*--68,418 mt (42 percent). No more than 5 percent (3,421 mt) of the shore-based whiting allocation may be taken before the shore-based fishery begins north of 42° N. lat.

(iv) *Tribal allocation*--See paragraph V.

(b) *Seasons*. The 2001 primary seasons for the whiting fishery start on the same dates as in 2000, as follows (see 50 CFR 660.323(a)(3)):

(i) *Catcher/processor sector*--May 15;

(ii) *Mothership sector*--May 15;

(iii) *Shore-based sector*--June 15 north of 42° N. lat.; April 1 between 42°-40°30' N. lat.; April 15 south of 40°30' N. lat.

(c) *Trip limits*. (i) *Before and after the regular season*. The ''per trip'' limit for whiting before and after the regular season for the shore-based sector is announced in Table 3, as authorized at 50 CFR 660.323(a)(3) and (a)(4). This trip limit includes any whiting caught shoreward of 100 fathoms (183 m) in the Eureka area.

(ii) *Inside the Eureka 100-fm (183 m) contour*. No more than 10,000 lb (4,536 kg) of whiting may be taken and retained, possessed, or landed by a vessel that, at any time during a fishing trip, fished in the fishery management area shoreward of the 100-fathom (183-m) contour (as shown on NOAA Charts 18580, 18600, and 18620) in the Eureka area.

(4) *Black rockfish. The regulations at 50 CFR 660.323(a)(1) state*: The trip limit for black rockfish (*Sebastes melanops*) for commercial fishing vessels using hook-and-line gear between the U.S.-Canada border and Cape Alava (48°09'30'' N. lat.) and between Destruction Island (47°40'00'' N. lat.) and Leadbetter Point (46°38'10'' N. lat.), is 100 lb (45 kg) or 30 percent, by weight of all fish on board, whichever is greater, per vessel per fishing trip.≥ These ≥per trip≥ limits apply to limited entry and open access fisheries, in conjunction with the cumulative trip limits and other management measures listed in Tables 4 and 5 of Section IV. The crossover provisions at paragraphs IV.A. (12) do not apply to the black rockfish per-trip limits.

C. Trip Limits in the Open Access Fishery

Open access gear is gear used to take and retain groundfish from a vessel that does not have a valid permit for the Pacific coast groundfish fishery with an endorsement for the gear used to harvest the groundfish. This includes longline, trap, pot, hook-and-line (fixed or mobile), set net and trammel net (south of 38° N. lat. only), and exempted trawl gear (trawls used to target non-groundfish species: pink shrimp or prawns, and, south of Pt. Arena, CA (38°57'30≥ N. lat.), California halibut or sea cucumbers). Unless otherwise specified, a vessel operating in the open access fishery is subject to, and must not exceed any trip limit, frequency limit, and/or size limit for the open access fishery. The crossover provisions at paragraph IV.A.(12) that apply to the limited entry fishery apply to the open access fishery as well.

(1) *All open access gear except exempt trawl gear*. The trip limits, size limits, seasons, and other management measures for open access groundfish gear, except exempted trawl gear, are listed in Table 5. The trip limit at 50 CFR 660.323(a)(i) for black rockfish caught with hook-and-line gear also applies. (The black rockfish limit is repeated at paragraph IV.B.4.)

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Table 5. 2001 Trip Limits[1/] for Open Access Gears
Read Section IV.A. NMFS Actions before using this table.
Exceptions for exempted gears at Section IV.C.

line	Species/groups	JAN-FEB	MAR-APR	MAY-JUN	JUL-AUG SEP-OCT	NOV-DEC
1	**Minor slope rockfish**					
2	North	500 lb/ 2 months				
3	South	5,000 lb/ 2 months				
4	**Splitnose - South**	200 lb/ month				
5	**Pacific ocean perch 4/**	100 lb/ month				
6	**Sablefish**					
7	North of 36° N. lat.	300 lb/ day, 2,700 lb/ 2 months				
8	South of 36° N. lat.	350 lb/ day				
9	**Thornyheads (longspine and shortspine combined)**					
10	North of 34°27' N. lat.	CLOSED 3/ -- Retention is Prohibited				
11	South of 34°27' N. lat.	50 lb/ day, no more than 2,000 lb/ 2 months				
12	**Arrowtooth**	200 lb/ month				
13	**Dover sole**	(included in "other" flatfish limit)				
14	**Petrale sole**	(included in "other" flatfish limit)				
15	**Nearshore flatfish**	(included in "other" flatfish limit)				
16	**"Other" flatfish 2/**	300 lb/ month				
17	**Whiting**	300 lb/ month				
18	**Minor shelf rockfish**					
19	North	100 lb/ month				
20	South					
21	40°10' - 34°27' N. lat.	200 lb/ month	CLOSED 3/		200 lb/ month	
22	South of 34°27' N. lat.	CLOSED 3/	200 lb/ month			
23	**Canary rockfish**					
24	North	50 lb/ month				
25	South					
26	40°10' - 34°27' N. lat.	50 lb/ month	CLOSED 3/		50 lb/ month	
27	South of 34°27' N. lat.	CLOSED 3/	50 lb/ month			
28	**Widow rockfish**					
29	North	3,000 lb/ month				
30	South					
31	40°10' - 34°27' N. lat.	3,000 lb/ month	CLOSED 3/		3,000 lb/month	
32	South of 34°27' N. lat.	CLOSED 3/	3,000 lb/ month			
33	**Yellowtail - North 4/**	100 lb/ month				
34	**Bocaccio - South 4/**					
35	40°10' - 34°27' N. lat.	200 lb/ month	CLOSED 3/		200 lb/ month	
36	South of 34°27' N. lat.	CLOSED 3/	200 lb/ month			
37	**Chilipepper - South 4/**					
38	40°10' - 34°27' N. lat.	2,500 lb/ month	CLOSED 3/		2,500 lb/ month	
39	South of 34°27' N. lat.	CLOSED 3/	2,500 lb/ month			
40	**Cowcod**	**Closed 3/ -- Retention is Prohibited**				
41	**Minor nearshore rockfish**					
42	North 6/	3,000 lb/ 2 months, no more than 900 lb of which may be species other than black or blue rockfish 5/				
43	South					
44	40°10' - 34°27' N. lat.	1,800 lb/ 2 months	CLOSED 3/	Shoreward of 20 ftm depth: 1,800 lb/ 2 months, otherwise CLOSED 3/	1,800 lb/ 2 months	
45	South of 34°27' N. lat.	Shoreward of 20 ftm depth: 1,800 lb/ 2 months, otherwise CLOSED 3/	1,800 lb/ 2 months			
46	**Lingcod 7/**					
47	North	CLOSED 3/		400 lb/ month		CLOSED 3/
48	South					
49	40°10' - 34°27' N. lat.	CLOSED 3/			400 lb/ month	CLOSED 3/
50	South of 34°27' N. lat.	CLOSED 3/		400 lb/ month		CLOSED 3/

1/ Trip limits apply coastwide unless otherwise specified. "North" means 40°10' N lat to the U.S. - Canada border "South" means 40°10' N lat to the U.S.-Mexico border. 40°10' N lat is about 20 nm south of Cape Mendocino, CA.
2/ "Other flatfish" means all flatfish at 50 CFR 660.302 except those in this Table 4 with a trip limit.
3/ Closed means that it is prohibited to take, retain, possess, or land the designated species in the time or area indicated. (See IV.A. (7).)
4/ Yellowtail rockfish and POP in the south, and bocaccio, and chilipepper rockfishes in the north are included in the trip limits for minor shelf rockfish in the appropriate area (Table 2).
5/ The "per trip" limit for black rockfish off Washington also applies. See paragraph IV.B.(4).
6/ See IV.C.(4) for limits specific to Pacific City, Oregon.
7/ The size limit for lingcod is 24 inches (61 cm) in the north, and 26 inches (66 cm) in the south, total length.
To convert pounds to kilograms, divide by 2.20462, the number of pounds in one kilogram.

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(2) *Groundfish taken with exempted trawl gear by vessels engaged in fishing for spot and ridgeback prawns, California halibut, or sea cucumbers.* (a) *Trip limits.* The trip limit is 300 lb (136 kg) of groundfish per fishing trip. Limits and closures in Table 5 also apply and are counted toward the 300 lb (136 kg) groundfish limit. In any landing by a vessel engaged in fishing for spot and ridgeback prawns, California halibut, or sea cucumbers with exempted trawl gear, the amount of groundfish landed may not exceed the amount of the target species landed, except that the amount of spiny dogfish (*Squalas acanthias*) landed may exceed the amount of target species landed. Spiny dogfish are limited by the 300 lb (136 kg) per trip overall groundfish limit. The daily trip limits for sablefish coastwide and thornyheads south of Pt. Conception and the overall groundfish ''per trip'' limit may not be multiplied by the number of days of the fishing trip.

(b) State law. These trip limits are not intended to supersede any more restrictive state law relating to the retention of groundfish taken in shrimp or prawn pots or traps.

(c) *Participation in the California halibut fishery.* A trawl vessel will be considered participating in the California halibut fishery if:

(i) It is not fishing under a valid limited entry permit issued under 50 CFR 660.333 for trawl gear;

(ii) All fishing on the trip takes place south of Pt. Arena; and

(iii) The landing includes California halibut of a size required by California Fish and Game Code section 8392(a), which states: ''No California halibut may be taken, possessed or sold which measures less than 22 inches (56 cm) in total length, unless it weighs 4 lbs (1.8144 kg) or more in the round, 3 and one-half lbs (1.587 kg) or more dressed with the head on, or 3 lbs (1.3608 kg) or more dressed with the head off. Total length means ''the shortest distance between the tip of the jaw or snout, whichever extends farthest while the mouth is closed, and the tip of the longest lobe of the tail, measured while the halibut is lying flat in natural repose, without resort to any force other than the swinging or fanning of the tail.''

(d) *Participation in the sea cucumber fishery.* A trawl vessel will be considered to be participating in the sea cucumber fishery if:

(i) It is not fishing under a valid limited entry permit issued under 50 CFR 660.333 for trawl gear;

(ii) All fishing on the trip takes place south of Pt. Arena; and

(iii) The landing includes sea cucumbers taken in accordance with California Fish and Game Code, section 8396, which requires a permit issued by the State of California.

(3) *Groundfish taken with exempted trawl gear by vessels engaged in fishing for pink shrimp* . (a) The trip limit is 500 lb (227 kg) of groundfish per day, multiplied by the number of days of the fishing trip, but not to exceed 1,500 lb (680 kg) of groundfish per trip. The following sublimits also apply and are counted toward the overall 500 lb (227 kg) per day and 1,500 lb (680 kg) per trip groundfish limits:

(i) Canary rockfish:

(A) April 1 through 30, 2001: 50 lb (23 kg) per month

(B) Starting May 1, 2001: 200 lb (91 kg) per month

(ii) Lingcod:

(A) April 1 through 30, 2001: closed

(B) Starting May 1, 2001: 400 lb (181 kg) per month, with a minimum size limit (total length) of 24 inches (61 cm) north of 40°10' N. lat. and 26 inches (66 cm) south of 40°10' N. lat.

(C) November 1 through December 31: closed.

(iii) Sablefish: Starting April 1, 2001: 2,000 lb (907 kg) per month.

(iv) Thornyheads: Closed north of Pt. Conception (34°27' N. lat.)

(b) For all other groundfish species, the trip limits in Table 5 apply to groundfish taken with exempted trawl gear by vessels engaged in fishing for pink shrimp and count toward the overall 500 lb (227 kg) per day and 1,500 lb (680 kg) per trip groundfish limits.

(c) In any trip in which pink shrimp trawl gear is used, the amount of groundfish landed may not exceed the amount of pink shrimp landed.

(d) Operating in pink shrimp and other fisheries during the same cumulative trip limit period. Notwithstanding section IV.A.(11), a vessel that takes and retains pink shrimp and also takes and retains groundfish in either the limited entry or another open access fishery during the same applicable cumulative limit period that it takes and retains pink shrimp (which may be 1 month or 2 months, depending on the fishery and the time of year), the vessel may retain the larger of the two limits, but only if the limit(s) for each gear or fishery are not exceeded when operating in that fishery or with that gear. The limits are not additive; the vessel may not retain a separate trip limit for each fishery.

(4) *Landings in Pacific City, OR.* For purposes of this paragraph, Pacific City, OR, is the area between 45°03'50'' N. lat. and 45°20'15'' N. lat.

(a) January 1 to March 31, 2001; October 1 to December 31, 2001: No more than 200 lb (91 kg) of minor nearshore rockfish may be landed per month in Pacific City, OR.

(b) April 1 to September 30, 2001: No more than 2,200 lb (998 kg) of minor nearshore rockfish may be landed per month in Pacific City, OR. Within the 2,200 lb (998 kg) monthly limit, no more than 700 lb (318 kg) may be species other than black or blue rockfish.

D. Recreational Fishery

(1) *California.* [Note: California law provides that, in times and areas when the recreational fishery is open, there is 20-fish bag limit for all species of finfish, within which no more than 10 fish of any one species may be taken or possessed by any one person.] For each person engaged in recreational fishing seaward of California, the following seasons and bag limits apply:

(a) *Rockfish.* (i) *Cowcod Conservation Areas.* Recreational fishing for groundfish is prohibited within the Cowcod Conservation Areas, as described above at IV.A.(20), except that fishing for minor nearshore rockfish is permissible in waters inside of the 20-fathom (36.9 m) depth contour.

(ii) *Seasons.* North of 40°10' N. lat., recreational fishing for rockfish is open from January 1 through December 31. South of 40°10' N. lat. and north of Point Conception (34°27' N. lat.), recreational fishing for rockfish is closed from March 1 through April 30. This area is also closed to recreational rockfish fishing from May 1 through June 30, except that fishing for minor nearshore rockfish is permitted inside the 20-fathom (36.9 m) depth contour. South of Point Conception (34°27' N. lat.), recreational fishing for rockfish is closed from January 1 through February 28, except that fishing for minor nearshore rockfish is permitted inside the 20-fathom (36.9 m) depth contour. Recreational fishing for cowcod is prohibited all year in all areas.

(iii) *Bag limits, boat limits, hook limits.* In times and areas when the recreational season for rockfish is open, there is a 2-hook limit per fishing line, and the bag limit is 10 rockfish per day, of which no more than 2 may be bocaccio (*Sebastes paucispinis*) and no more than 1 may be canary rockfish. Cowcod may not be retained. Bocaccio and canary rockfish are not minor nearshore rockfish and thus, may not be retained in the area between 40°10' N. lat. and Point Conception (34°27' N. lat.) from May 1 through June 30. [Note: California scorpionfish, *Scorpaena guttata*, are subject to California's 10-fish bag limit per species, but are not

counted toward the 10-rockfish bag limit.] Multi-day limits are authorized by a valid permit issued by California and must not exceed the daily limit multiplied by the number of days in the fishing trip.

(iv) *Size limits.* The following rockfish size limits apply: bocaccio may be no smaller than 10 inches (25 cm), and California scorpionfish may be no smaller than 10 inches (25 cm).

(v)*Dressing/Fileting* . Rockfish skin may not be removed when fileting or otherwise dressing rockfish taken in the recreational fishery. The following rockfish filet size limits apply: bocaccio filets may be no smaller than 5 inches (12.8 cm); California scorpionfish filets may be no smaller than 5 inches (12.8 cm); and brown-skinned rockfish filets may be no smaller than 6.5 inches (16.6 cm). ''Brown-skinned'' rockfish include the following species: brown (*S. auriculatus*), calico (*S. dalli*), copper (*S. caurinus*), gopher (*S. carnatus*), kelp (*S. atrovirens*), olive (*S. serranoides*), speckled (*S. ovalis*), squarespot (*S.* hopinski), and yellowtail (*S. flavidus*).

(b) *Roundfish* (Lingcod, cabezon, kelp greenling--(i) *Seasons.* South of 40°10' N. lat. and north of Point Conception (34°27' N. lat.), recreational fishing for lingcod is closed from March 1 through June 30. South of Point Conception (34°27' N. lat.), recreational fishing for lingcod is closed from January 1 through February 28.

(iii) *Bag limits, boat limits, hook limits.* In times and areas when the recreational season for lingcod is open, there is a 2-hook limit per fishing line, and the bag limit is 2 lingcod per day. Multi-day limits are authorized by a valid permit issued by California and must not exceed the daily limit multiplied by the number of days in the fishing trip.

(iv) *Size limits.* The following roundfish size limits apply: lingcod may be no smaller than 26 inches (66 cm) total length, cabezon (*Scorpaenichthys marmoratus*) may be no smaller than 15 inches (38 cm); and kelp greenling (*Hexagrammos decagrammus*) may be no smaller than 12 inches (30 cm).

(v) *Dressing/Fileting.* Cabezon and kelp greenling taken in the recreational fishery may not be fileted at sea. Lingcod filets may be no smaller than 18 inches (46.1 cm).

(2) *Oregon.* The bag limits for each person engaged in recreational fishing seaward of Oregon are: 1 lingcod per day, which may be no smaller than 24 inches (61 cm) total length; and 10 rockfish per day, of which no more than 1 may be canary rockfish.

(3) *Washington.* For each person engaged in recreational fishing seaward of Washington, the following seasons and bag limits apply:

(a) *Rockfish.* There is a rockfish bag limit of no more than 10 rockfish per day, of which no more than 2 may be canary or yelloweye rockfish (*S. ruberrimus*).

(b) *Lingcod.* Recreational fishing for lingcod is closed between January 1, 2001, and March 15, 2001, and between October 15, 2001, and December 31, 2001. When the recreational season for lingcod is open, there is a bag limit of 2 lingcod per day, which may be no smaller than 24 inches (61 cm) total length.

V. Washington Coastal Tribal Fisheries

In 1994, the U.S. government formally recognized that the four Washington Coastal Tribes (Makah, Quileute, Hoh, and Quinault) have treaty rights to fish for groundfish, and concluded that, in general terms, the quantification of those rights is 50 percent of the harvestable surplus of groundfish available in the tribes' usual and accustomed (U and A) fishing areas (described at 50 CFR 660.324).

A tribal allocation is subtracted from the species OY before limited entry and open access allocations are derived. The treaty tribal fisheries for sablefish, black rockfish, and whiting are separate fisheries, not governed by the limited entry or open access regulations or allocations. The tribes regulate these fisheries so as not to exceed their allocations.

The tribal allocation for black rockfish is the same in 2001 as in 2000. As with non-tribal sablefish allocations, the tribal allocation for sablefish in 2001 is revised from prior years. In the past, 10 percent of the total catch OY was deducted for discard in all fisheries. Then, the tribal sablefish allocation was set at 10 percent of that landed catch OY, with the remaining 90 percent divided between various non-tribal fisheries. For 2001 and beyond, the Council recommended dividing the total catch OY according to the customary allocations for all sectors, including 10 percent for the tribes, and then reducing the allocations for each fishing sector by sector-specific discard mortality rates. Tribal sablefish fisheries are primarily longline fisheries and are estimated to have a 3-percent discard mortality rate. Thus, the tribal sablefish allocation is 10 percent of the total catch OY, 689.5 mt, less 3 percent discard mortality (20.7 mt), or approximately 669 mt.

For 2001, the tribes proposed a Pacific whiting allocation of 27,500 mt, and the Council voted to adopt this proposal. The 2001 allocation is based on a ''sliding scale'' proposal presented by the Makah Tribe in 1998 that determines the tribal allocation based on the level of the overall U.S. OY. The ''sliding scale'' proposal was previously used in both 1999 and 2000 to determine the tribal allocation. As discussed earlier, the U.S. whiting OY is reduced in 2001, based on lower estimated stock abundance, to 190,400 mt. Under the 1998 Makah ''sliding scale'' proposal, a 190,400 mt U.S. OY results in a 27,500 mt Makah whiting allocation. No other tribes proposed to harvest whiting in 2001.

The right of the Washington coastal treaty tribes to harvest Pacific whiting in accordance with the legal principles established in the ongoing case of U.S. v. Washington, No. 9213, Phase I (W.D. Wash), was sustained in Subproceeding 96-2, Order Granting Makah's Motion for Summary Judgment (Nov. 5, 1996), and in the separate, consolidated cases of *Midwater Trawlers Cooperative* v. *U.S. Department of Commerce*, Civ. Nos. 96-808R, C96-671R, C99-415R, and C99-500R (W.D. Wash.), Order Granting Defendants' Motions for Summary Judgment (July 26, 2000). In the latter cases, the court held that the tribes have a treaty right to harvest Pacific whiting; that the Federal defendants did not act arbitrarily and capriciously in recognizing the tribes' right; that the Secretary of Commerce did not act arbitrarily and capriciously in extending the tribes' usual and accustomed fishing areas into the United States' exclusive economic zone; that the Secretary appropriately recognized the tribes as co-managers of the shared resources in the final rule providing for tribal groundfish allocations (see 50 CFR 660.324(d)); and that the 1999 tribal allocation, which represented a compromise of different views of the treaty entitlement, was not arbitrary and capricious. This decision has been appealed to the Ninth Circuit Court of Appeals by non-treaty fishers and by the State of Oregon, and briefs will be submitted in the near future.

Quantification of the treaty right remains an issue. Under the applicable treaty rights law, Washington coast treaty tribes have treaty rights to harvest half the harvestable surplus of whiting found in their usual and accustomed fishing areas, determined according to the conservation necessity principle. The conservation necessity principle means that the determination of the amount of fish available for harvest must be based solely on resource conservation needs. This determination is difficult because, with the exception of cases involving Pacific halibut (*Makah* v. *Brown* Civil No. C-85- 1606R (W.D. Wash.) and *U.S.* v. *Washington*,

Subproceeding No. 92-1 (W.D. Wash.)), the legal and technical precedents are based on the biology, harvest, and conservation requirements for Pacific salmon and shellfish, which are very different than Pacific whiting. Quantifying the tribal right to Pacific whiting is further complicated by data limitations, and by scientific uncertainties surrounding Pacific whiting biology and conservation needs.

In 1996, the Makah initiated a subproceeding in *U.S.* v. *Washington*, Civil No. 9213-Phase I, Subproceeding No. 96-2, regarding their treaty right to whiting, including the issue of the appropriate quantification of that right. This subproceeding is ongoing, with briefing scheduled on the quantification issue in early 2001. However, taking into account the existing case law in *U.S.* v. *Washington*, the Makah Tribe's 1998 ''sliding scale'' proposal and its supporting materials, the Council's recommendation for the 2001 tribal allocation, and the continuing uncertainties surrounding a precise quantification of the tribal right, NMFS will allocate 27,500 mt of Pacific whiting in 2001 to the Makah Tribe.

For some species on which the tribes have a modest harvest, no specific allocation has been determined. Rather than try to reserve specific allocations for the tribes, which may not be needed by the tribes, NMFS is establishing trip limits recommended by the tribes and the Council to accommodate modest tribal fisheries. For lingcod, all tribal fisheries are restricted to 300 lb (126 kg) per trip. Tribal fisheries are not expected to take more than 3 mt of lingcod in 2001. For the Sebastes complex and other rockfish species, the 2001 tribal longline and trawl fisheries will operate under trip and cumulative limits. Tribal fisheries will operate under 300 lb (136 kg) per trip limits each for canary rockfish and for thornyheads, and under the same trip limits as the limited entry fisheries for all other rockfish. A 300-lb (136-kg) canary rockfish trip limit is expected to result in landings of 1,000-2,000 lb (0.5-1 mt). A 300-lb (136-kg) thornyhead limit is expected to result in landings of 8,000-9,000 lb (3-4 mt). Because of the small expected tribal groundfish catch, it is not anticipated that tribal trip limits will be reduced during the year unless OY's are achieved or unless inseason catch statistics demonstrate that the tribes have taken half of the available harvest in the tribal U and A fishing areas.

The Assistant Administrator (AA) announces the following tribal allocations for 2001, including those that are the same as in 2000. Trip limits for certain species were recommended by the tribes and the Council and are specified here with the tribal allocations:

A. Sablefish

The tribal allocation is 669 mt, 10 percent of the total catch OY, less 3 percent estimated discard mortality.

B. Rockfish

(1) For the commercial harvest of black rockfish off Washington State, a HG of: 20,000 lb (9,072 kg) north of Cape Alava (48°09'30'' N. lat.) and 10,000 lb (4,536 kg) between Destruction Island (47°40′00'' N. lat.) and Leadbetter Point (46°38'10'' N. lat.).

(2) Thornyheads are subject to a 300-lb (136-kg) trip limit.

(3) Canary rockfish are subject to a 300-lb (136-kg) trip

(4) Other rockfish are subject to the same trip limits as the limited entry fishery, as published in this document. The tribal limit will not change unless the tribal limits are revised separately from the limited entry limits.

C. Lingcod

Lingcod are subject to a 300-lb (136-kg) trip limit.

D. Pacific whiting

The tribal allocation is 27,500 mt.

VI. Issuance of Exempted Fishing Permits (EFPs)

At the November 2000, Council meeting, NMFS received an application from the States of Washington, Oregon, and California for renewal of the EFPs for the shore-based whiting fishery for 2001. An opportunity for public comment was provided during the Council meeting. The Council recommended that NMFS issue the EFPs, as requested by the States. Renewal of these EFPs, to about 40 vessels, would continue an ongoing program to collect information on the incidental catch of salmon and non-whiting groundfish in whiting harvests delivered to shore-based processing facilities.

Because whiting deteriorates rapidly, it must be handled quickly and immediately chilled to maintain the quality. As a result, many vessels dump catch directly or near directly into the hold and are unable to effectively sort their catch. The issuance of EFPs will allow vessels to delay sorting of prohibited species and groundfish caught in excess of cumulative trip limits until offloading. Delaying sorting until the vessel offloads will allow state biologists to collect incidental catch data for total catch estimates while maintaining whiting quality. Without an EFP, groundfish regulations at 50 CFR 660.306(b) require vessels to sort out prohibited species and return them to sea as soon as practicable with minimum injury. To allow state biologists to sample unsorted whiting, it is also necessary to include provisions for potential overages of groundfish trip limits which would be otherwise prohibited by regulations at 50 CFR 660.306(h). NMFS approves the request to renew the EFP for the shore-based whiting fishery in 2001.

Classification

The final specifications and management measures for 2001 are issued under the authority of, and are in accordance with, the Magnuson-Stevens Act, the FMP, and 50 CFR parts 600 and 660 subpart G (the regulations implementing the FMP).

This package of specifications and management measures is a delicate balance designed to allow as much harvest of healthy stocks as possible, while protecting overfished and other depressed stocks. Delay in implementation of the measures could upset that balance and cause harm to some stocks and it could require unnecessarily restrictive measures later in the year to make up for the late implementation. Much of the data necessary for these specifications and management measures came from the current fishing year. The Assistant Administrator for Fisheries, NOAA (AA) has determined that there is good cause under 5 U.S.C. 553(b)(B) to waive prior notice and opportunity for public comment for the specifications and management measures. Because of the timing of the receipt, development, review, and analysis of the fishery information necessary for setting the initial specifications and management measures, and the need to have these specifications and management measures in effect at the beginning of the 2001 fishing year, Amendment 4 to the FMP, implemented on January 1, 1991, recognized these timeliness considerations and set up a system by which the interested public is notified, through Federal Register publication and Council mailings, of Council meetings and of the development of these measures and is provided the opportunity to comment during the Council process. The public participated in GMT, Groundfish Advisory Subpanel, SSC, and Council meetings in September and November 2000 where these recommendations were formulated. Additional public comments on the specifications and management measures will be accepted

for 30 days after publication of this document in the **Federal Register**.

There is no burden for the public to come into compliance with the harvest specifications and management measures designed to achieve those specifications that are announced by this rule. As described above, the interested public has participated in the Council process to formulate these regulations. The Council has provided information to the industry on the above management measures and specifications through the newsletters that it sends to fishery participants. Moreover, NMFS has provided notice through the U.S. Coast Guard Notice to Mariners, and the states of Washington, Oregon, and California also disseminate information. Therefore, the AA finds, for good cause under 5 U.S.C. 553(d)(3), that it is unnecessary to delay for 30 days the effective date of the specifications and management measures. Because of the need to have these specifications and management measures in effect as close to the beginning of the 2001 fishing year as possible, the AA also finds, for good cause under 5 U.S.C. 553(d)(3), that it is contrary to the public interest to delay for 30 days the effective date of the specifications and management measures.

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

Because prior notice and opportunity for public comment are not required for the annual specifications and management measures by 5 U.S.C. 553, or any other law, the analytical requirements of the Regulatory Flexibility Act, 5 U.S.C. 601 *et seq.*, are not applicable.

This action refers to a collection-of-information requirements subject to the Paperwork Reduction Act (PRA). Permit requirements have been approved by OMB under control number 0648-203 for Federal fisheries permits. The public reporting burden for applications for exempted fishery permits is estimated at 1 hour per response; the burden for reporting by exempted fishing permittees is estimated at 30 minutes per response. These estimates include the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and revising the collection of information. Send comments regarding these burden estimates or any other aspect of the data requirements, including suggestions for reducing the burden to NMFS and to OMB (see **ADDRESSES**).

Notwithstanding any other provisions of the law, no person is required to respond to, nor shall a 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 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**).

NMFS issued Biological Opinions (BOs) under the Endangered Species Act on August 10, 1990, November 26, 1991, August 28, 1992, September 27, 1993, May 14, 1996, and December 15, 1999 pertaining to the effects of the groundfish fishery on chinook salmon (Puget Sound, Snake River spring/summer, Snake River fall, upper Columbia River spring, lower Columbia River, upper Willamette River, Sacramento River winter, Central Valley, California coastal), coho salmon (Central California coastal, southern Oregon/northern California coastal, Oregon coastal), chum salmon (Hood Canal, Columbia River), sockeye salmon (Snake River, Ozette Lake), steelhead (upper, middle and lower Columbia River, Snake River Basin, upper Willamette River, central California coast, California Central Valley, south-central California, southern California), and cutthroat trout (Umpqua River, southwest Washington/Columbia River). NMFS has concluded that implementation of the FMP for the Pacific Coast groundfish fishery is not expected to jeopardize the continued existence of any endangered or threatened species under the jurisdiction of NMFS, or result in the destruction or adverse modification of critical habitat. This action is within the scope of these consultations. NMFS has re-initiated consultation on the Pacific whiting fishery associated with the BO issued on December 15, 1999. During the 2000 whiting season, the whiting fisheries exceeded the chinook bycatch amount specified in the Biological Opinion's incidental take statement's incidental take estimates, 11,000 fish, by approximately 500 fish. The re-initiation will focus primarily on additional actions that the whiting fisheries would take to reduce chinook interception, such as time/area management. NMFS expects that the re-initiated BO will be complete by May 2001. During the reinitiation, fishing under the FMP is within the scope of the December 15, 1999 BO, so long as the annual incidental take of chinook stays under the 11,000 fish bycatch limit. Because the majority of the catch will occur in late spring and summer. It is highly unlikely that the 11,000 fish bycatch limit will be exceeded.

The Council prepared an Environmental Impact Statement (EIS) for the FMP in 1982 and prepared Supplemental EISs for Amendments 4(1990) and 6 (1992) in accordance with the National Environmental Policy Act (NEPA). In addition, the Council prepared an environmental assessment for this action.

This action would set 2001 fishery specification and management measures that are designed to rebuild overfished stocks through constraining direct and incidental mortality, to prevent overfishing, and to achieve as much of the OYs as practicable for healthier groundfish stocks managed under the FMP. Five species managed under the FMP have been determined to be overfished: lingcod, bocaccio, POP, canary rockfish, and cowcod. NMFS is declaring two additional species (widow and darkblotched rockfish) overfished. Under the Magnuson-Stevens Act requirements for protecting overfished species, the 2001 management measures have been designed to keep directed and incidental catch of overfished species at levels that will allow those species to rebuild their populations. For 2001, commercial landings limits and recreational bag limits have been reduced, and time area closures have been expanded to protect overfished species. These fisheries have been operating under protective measures for several years.

Based on the biological, physical and socio-economic impacts of the alternatives that have been assessed in the EA, it was determined that implementation of the 2001 specifications and management measures would not significantly affect the quality of the human environment. Therefore, the preparation of an EIS for this action is not required by Section 102(2)(C) of NEPA or its implementing regulations.

Dated: January 4, 2001.

William T. Hogarth,

Deputy Assistant Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 01–560 Filed 1–5–01; 4:17 pm]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 66, No. 8
Thursday, January 11, 2001

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 THE TREASURY

Internal Revenue Service

26 CFR Part 1

[REG–116048–99]

RIN 1545–AX63

Stock Transfer Rules: Supplemental Rules

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Withdrawal of notice of proposed rulemaking.

SUMMARY: This document withdraws proposed regulations relating to an election available to certain taxpayers under section 367(b). The withdrawal corresponds to the upcoming expiration of the availability of the election.

FOR FURTHER INFORMATION CONTACT: Mark Harris at (202) 622–3860 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

On January 24, 2000, the IRS and Treasury published in the **Federal Register** proposed regulations (65 FR 3629) (the proposed regulations), temporary regulations (65 FR 3586) (the temporary regulations), and final regulations (65 FR 3589) (the final regulations) under section 367(b) of the Internal Revenue Code. The proposed and temporary regulations provide a modified version of an election contained in the proposed section 367(b) regulations issued on August 26, 1991 (1991 proposed regulations), which was not adopted in the final regulations. This election allows certain taxpayers to recognize the gain (but not the loss) realized in certain section 367(b) exchanges, rather than including the all earnings and profits amount in income. The preamble to the final regulations explains the reasons for not including the taxable exchange election in the final regulations (65 FR 3589 at 3592).

The IRS and Treasury issued the proposed and temporary regulations in order to provide taxpayers with an opportunity to comment on the decision not to include the taxable exchange election in the final regulations. Section 1.367(b)–3(b)(4)(ii) of the proposed and temporary regulations provide that the taxable exchange election is applicable for transactions that occur between February 23, 2000, and February 24, 2001. A public hearing was scheduled for April 20, 2000, and written comments were to be received by April 24, 2000. No one requested to speak at the public hearing, and no comments were submitted. In particular, the IRS and Treasury have not received any comments suggesting revisions to the effective date articulated in § 1.367(b)–3(b)(4)(ii). Accordingly, this document withdraws § 1.367(b)–3(b)(4) of the proposed regulations published in the **Federal Register** on January 24, 2000 (65 FR 3629).

List of Subjects in 26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements.

Withdrawal of Proposed Amendments to the Regulations

Accordingly, under the authority of 26 U.S.C. 7805, proposed amendments to 26 CFR part 1 relating to § 1.367(b)–3(b)(4) published January 24, 2000 (65 FR 6329), are withdrawn.

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

[FR Doc. 01–492 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[REG–103320–00]

RIN 1545–AX85

Disclosure of Returns and Return Information to Designee of Taxpayer

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking.

SUMMARY: In the Rules and Regulations section of this issue of **Federal Register**, the IRS is issuing a temporary regulation relating to the disclosure of returns and return information to the designee of a taxpayer. The text of that temporary regulation also serves as the text of this regulation.

DATES: Written and electronic comments and requests for a public hearing must be received by April 11, 2001.

ADDRESSES: Send submissions to: CC:M&SP:RU (REG–103320–00), room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand delivered Monday through Friday between the hours of 8 a.m. and 5 p.m. to: CC:M&SP:RU (REG–103320–00), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC. Alternatively, taxpayers may submit comments electronically via the Internet by selecting the ''Tax Regs'' option on the IRS Home Page, or by submitting comments directly to the IRS Internet site: http://www.irs.gov/prod/tax_regs/comments/html.

FOR FURTHER INFORMATION CONTACT: Joseph Conley (202) 622–4580 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

Section 6103(c), as amended by section 1207 of the Taxpayer Bill of Rights II, Public Law 104–168 (110 Stat. 1452), authorizes the IRS to disclose returns and return information to such person or persons as the taxpayer may designate in a request for or consent to disclosure or to any other person at the taxpayer's request to the extent necessary to comply with a request for information or assistance made by the taxpayer to such other person. Disclosure is permitted subject to such requirements and conditions as may be prescribed by regulations. With the amendment in 1996, Congress eliminated the longstanding requirement that disclosures to designees of the taxpayer must be pursuant to the written request or consent of the taxpayer. The purpose of this amendment to section 6103(c) was to assist the IRS in developing a paperless tax administration system that relies on, among other things, electronic communication. H.R. Rep. No. 104–506, at 49 (1996), reprinted in 1996 U.S.C.A.N. 1143, 1172.

On October 3, 1980, a final regulation (TD 7723) relating to the disclosure of tax returns and return information to a

person designated by the taxpayer in a written request or consent was published in the **Federal Register** (45 FR 65564). Since the publication of this final regulation, the IRS has determined that further guidance on written consent requirements is necessary.

This document contains a proposed regulation that authorizes the disclosure of tax returns and return information to a designee of the taxpayer pursuant to nonwritten requests or consents authorizing the disclosures. Such proposed regulation also amends the existing regulation to clarify the rules applicable to written requests or consents to disclosure.

The text of the temporary regulation published in this issue of the **Federal Register** serves as the text of this proposed regulation. The preamble to the temporary regulation explains the regulation.

Special Analysis

It has been determined that this Treasury decision is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It is hereby certified that this proposed regulation will not impose a significant economic impact on a substantial number of small entities. The regulation is intended to reduce the burden on taxpayers and to facilitate the development of a paperless tax administration system. The prior regulation required that a taxpayer provide a written request or consent before the IRS could disclose the taxpayer's return information to a designee of the taxpayer; this regulation permits such a disclosure, under certain specified circumstances, pursuant to the taxpayer's nonwritten request or consent. The regulation also provides parameters for the development of consents for the electronic filing program, and it reduces the burden on taxpayers in combined Federal-State return filing programs by facilitating the electronic filing of a Federal-State return by means of a single electronic transmission.

Pursuant to section 7805(f) of the Internal Revenue Code, this notice of proposed rulemaking will be submitted to the Chief Counsel of Small Business Administration for comment on its impact on small businesses.

Comments and Requests for a Public Hearing

Before the proposed regulation is adopted as a final regulation, consideration will be given to any electronic and written comments (a signed original and eight (8) copies) that are submitted timely to the IRS. The IRS and Treasury Department specifically request comments on consents or notices authorizing disclosures in an electronic environment. Additionally, the IRS and Treasury Department specifically request comments on the clarity of the proposed regulation and how it can be made easier to understand. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of this regulation is Jamie Bernstein, Office of the Associate Chief Counsel, Procedure and Administration (Disclosure & Privacy Law Division). However, other personnel from the IRS and Treasury Department participated in its development.

List of Subjects in 26 CFR part 301

Employment taxes, Estate taxes, Excise taxes, Gift taxes, Income taxes, Penalties, Reporting and recordkeeping requirements.

Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 301 is amended as follows:

PART 301—PROCEDURE AND ADMINISTRATION

Paragraph 1. The authority citation for part 301 is amended by adding an entry in numerical order to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Section 301.6103(c)–1 also issued under 26 U.S.C. 6103(c). * * *

Par. 2. Section 301.6103(c)–1 is added to read as follows:

§ 301.6103(c)–1 Disclosure of returns and return information to designee of taxpayer.

[The text of this proposed section is the same as the text of § 301.6103(c)–1T published elsewhere in this issue of the **Federal Register**.]

Robert E. Wenzel,

Deputy Commissioner of Internal Revenue.

[FR Doc. 01–486 Filed 1–10–01; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 914

[SPATS No. IN–151–FOR]

Indiana Regulatory Program

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

ACTION: Proposed rule; public comment period and opportunity for public hearing.

SUMMARY: The Office of Surface Mining Reclamation and Enforcement (OSM) is opening the public comment period for a previously submitted proposed amendment to the Indiana regulatory program (Indiana program) under the Surface Mining Control and Reclamation Act of 1977 (SMCRA). Indiana proposes the addition of a statute concerning post mining land use changes as nonsignificant permit revisions. The amendment is intended to revise the Indiana program to improve operational efficiency. This document gives the times and locations that the Indiana program and proposed amendment to that program are available for your inspection, the comment period during which you may submit written comments on the amendment, and the procedures that we will follow for the public hearing, if one is requested.

DATES: We will accept written comments until 4:00 p.m., e.s.t., February 12, 2001. If requested, we will hold a public hearing on the amendment on February 5, 2001. We will accept requests to speak at the hearing until 4:00 p.m., e.s.t. on January 26, 2001.

ADDRESSES: You should mail or hand deliver written comments and requests to speak at the hearing to Andrew R. Gilmore, Director, Indianapolis Field Office, at the address listed below.

You may review copies of the Indiana program, the amendment, a listing of any scheduled public hearings, and all written comments received in response to this document at the addresses listed below during normal business hours, Monday through Friday, excluding holidays. You may receive one free copy of the amendment by contacting OSM's Indianapolis Field Office.

Andrew R. Gilmore, Director, Indianapolis Field Office, Office of Surface Mining Reclamation and Enforcement, Minton-Capehart Federal Building, 575 North Pennsylvania Street, Room 301,

Indianapolis, IN 46204, Telephone: (317) 226–6700.
Indiana Department of Natural Resources, Bureau of Mine Reclamation, 402 West Washington Street, Room W–295, Indianapolis, Indiana 46204, Telephone: (317) 232–1291.
Indiana Department of Natural Resources, Division of Reclamation, R.R. 2, Box 129, Jasonville, Indiana 47438–9517, Telephone: (812) 665–2207.

FOR FURTHER INFORMATION CONTACT: Andrew R. Gilmore, Director, Indianapolis Field Office. Telephone: (317) 226–6700. Internet: INFOMAIL@indgw.osmre.gov.

SUPPLEMENTARY INFORMATION:

I. Background on the Indiana Program

On July 29, 1982, the Secretary of the Interior conditionally approved the Indiana program. You can find background information on the Indiana program, including the Secretary's findings, the disposition of comments, and the conditions of approval in the July 26, 1982, **Federal Register** (47 FR 32107). You can find later actions on the Indiana program at 30 CFR 914.10, 914.15, and 914.16.

By letter dated May 14, 1998 (Administrative Record No. IND–1606), Indiana submitted a proposed amendment to us accordance with SMCRA. The proposed amendment concerned revisions of and additions to the Indiana Code (IC) made by House Enrolled Act (HEA) No. 1074. Indiana intended to revise its program to incorporate the additional flexibility afforded by SMCRA and to provide the guidelines for permit revisions, including incidental boundary revisions. We announced receipt of the proposed amendment in the May 29, 1998, **Federal Register** (63 FR 29365), and invited public comment on its adequacy. The public comment period for the amendment closed June 29, 1998. During our review of the proposed amendment, we identified concerns relating to the proposed amendment. We notified Indiana of these concerns by letter dated September 15, 1998 (Administrative Record No. IND–1621). By letter dated December 21, 1998 (Administrative Record No. IND–1627), Indiana responded to our concerns by submitting additional explanatory information. Because Indiana did not make any substantive revisions to the amendment, we did not reopen the public comment period. On March 16, 1999, we approved Indiana's proposed amendment, with three exceptions (64 FR 12890). Specifically, we did not approve the amendment at IC 14–34–5–7(a) concerning guidance for permit revisions; the amendment at IC 14–34–5–8.2(4) concerning postmining land use changes; and the amendment at IC 14–34–5–8.4(c)(2)(K) concerning minor field revisions for temporary cessation of mining. On May 26, 1999, at Indiana's request, we provided clarification of our decision on Indiana's amendment (64 FR 28362).

On May 14, 1999, the Indiana Coal Council (ICC) filed a lawsuit against OSM for the disapproval of Indiana's amendment at IC 14–34–5–7(a) and IC 14–34–5–8.2(4). On September 25, 2000, the U.S. District Court for the Southern District of Indiana handed down its decision on the ICC's lawsuit. The court found that, in the case of IC 14–34–5–7(a) concerning guidance for permit revisions, OSM had not acted arbitrary and capricious. Therefore, the court upheld our decision. However, in the case of IC 14–34–5–8.2(4) concerning postmining land use changes, the Court found that our decision was arbitrary and capricious, and remanded the matter to OSM for ''further consideration.'' In accordance with the Court's ruling, we are opening the public comment period for section 8.2(4) of Indiana's proposed amendment submitted on May 15, 1998, so that we can properly consider whether the proposed amendment satisfies the applicable program approval criteria of 30 CFR 732.15.

II. Description of the Proposed Amendment

The full text of the proposed program amendment submitted by Indiana is available for public inspection at the locations listed above under **ADDRESSES**. A discussion of the proposed amendment is presented below.

IC 14–34–5–8.2(4), Nonsignificant Permit Revisions

Indiana proposes to add language at IC 14–34–5–8.2(4) to provide that postmining land use changes other than residential, commercial or industrial, recreational, or developed water resources meeting MSHA requirements for a significant impoundment are nonsignificant permit revisions, and therefore are not subject to the notice and hearing requirements of IC 14–34.

III. Public Comment Procedures

Under the provisions of 30 CFR 732.17(h), we are seeking comments on whether the proposed amendment satisfies the applicable program approval criteria of 30 CFR 732.15. If we approve the amendment, it will become part of the Indiana program.

Written Comments: If you submit written or electronic comments on the proposed rule during the 30-day comment period, they should be specific, should be confined to issues pertinent to the notice, and should explain the reason for your recommendation(s). We may not be able to consider or include in the Administrative Record comments delivered to an address other than the one listed above (see **ADDRESSES**).

Electronic Comments: Please submit Internet comments as an ASCII, WordPerfect, or Word file avoiding the use of special characters and any form of encryption. Please also include ''Attn: SPATS NO. IN–151–FOR'' and your name and return address in your Internet message. If you do not receive a confirmation that we have received your Internet message, contact the Indianapolis Field Office at (317) 226–6700.

Availability of Comments: Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours at OSM's Indianapolis Field Office (see **ADDRESSES**). Individual respondents may request that we withhold their home address from the administrative record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the administrative 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.

Public Hearing: If you wish to speak at the public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT** by 4:00 p.m., e.s.t. on January 26, 2001. We will arrange the location and time of the hearing with those persons requesting the hearing. If no one requests an opportunity to speak at the public hearing, the hearing will not be held.

To assist the transcriber and ensure an accurate record, we request, if possible, that each person who speaks at a public hearing provide us with a written copy of his or her testimony. The public hearing will continue on the specified date until all persons scheduled to speak have been heard. If you are in the audience and have not been scheduled to speak and wish to do so, you will be

allowed to speak after those who have been scheduled. We will end the hearing after all persons scheduled to speak and persons present in the audience who wish to speak have been heard.

If you are disabled and need a special accommodation to attend a public hearing, contact the person listed under **FOR FURTHER INFORMATION CONTACT**.

Public Meeting: If only one person requests an opportunity to speak at a hearing, a public meeting, rather than a public hearing, may be held. If you wish to meet with us to discuss the proposed amendment, you may request a meeting by contacting the person listed under **FOR FURTHER INFORMATION CONTACT**. All such meetings are open to the public and, if possible, we will post notices of meetings at the locations listed under **ADDRESSES**. We will also make a written summary of each meeting a part of the Administrative Record.

IV. 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 regulations.

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 under 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 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 regulations.

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 914

Intergovernmental relations, Surface mining, Underground mining.

Dated: January 3, 2001.

Richard J. Seibel,

Acting Regional Director, Mid-Continent Regional Coordinating Center.

[FR Doc. 01–835 Filed 1–10–01; 8:45 am]

BILLING CODE 4310–05–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 3

RIN 2900–AK63

Disease Associated With Exposure to Certain Herbicide Agents: Type 2 Diabetes

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) is proposing to amend its adjudication regulations concerning presumptive service connection for certain diseases for which there is no record during service. This proposed amendment is necessary to implement a decision of the Secretary of Veterans Affairs under the authority granted by the Agent Orange Act of 1991 that there is a positive association between exposure to herbicides used in the Republic of Vietnam during the Vietnam era and the subsequent development of Type 2 diabetes. The intended effect of this proposed amendment is to establish presumptive service connection for that condition based on herbicide exposure.

DATES: Comments must be received on or before March 12, 2001.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1154, Washington, DC 20420; or fax comments to (202) 273–9289; or e-mail comments to *OGCRegulations@mail.va.gov.* Comments should indicate that they are submitted in response to ''RIN 2900–AK63.'' All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8:00 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Bill Russo, Regulations Staff, Compensation and Pension Service, Veterans Benefits Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, telephone (202) 273–7210.

SUPPLEMENTARY INFORMATION: Section 3 of the Agent Orange Act of 1991, Pub. L. 102–4, 105 Stat. 11, directed the Secretary to seek to enter into an agreement with the National Academy of Sciences (NAS) to review and summarize the scientific evidence concerning the association between exposure to herbicides used in support of military operations in the Republic of Vietnam during the Vietnam era and each disease suspected to be associated with such exposure. Congress mandated that NAS determine, to the extent possible: (1) Whether there is a statistical association between the suspect diseases and herbicide exposure, taking into account the strength of the scientific evidence and the appropriateness of the methods used to detect the association; (2) the increased risk of disease among individuals exposed to herbicides during service in the Republic of Vietnam during the Vietnam era; and (3) whether there is a plausible biological mechanism or other evidence of a causal relationship between herbicide exposure and the suspect disease. Section 3 of Pub. L. 102–4 also required that NAS submit reports on its activities every two years (as measured from the date of the first report) for a ten-year period.

Section 2 of Pub. L. 102–4 provides that whenever the Secretary determines, based on sound medical and scientific evidence, that a positive association (*i.e.,* the credible evidence for the association is equal to or outweighs the credible evidence against the association) exists between exposure of humans to an herbicide agent (*i.e.,* a chemical in an herbicide used in support of the United States and allied military operations in the Republic of Vietnam during the Vietnam era) and a disease, the Secretary will publish regulations establishing a presumptive service connection for that disease. Presumptive service connection relaxes the evidentiary burden, so that the claimant need not provide direct evidence of a link between his or her disease and the claimant's exposure to Agent Orange. Instead, such a link is presumed and may be rebutted only if there is affirmative evidence to the contrary.

If the Secretary determines that a presumption of service connection is not warranted, he is to publish a notice of that determination, including an explanation of the scientific basis for that determination. The Secretary's determination must be based on consideration of the NAS reports and all other sound medical and scientific information and analysis available to the Secretary.

(Under Section 2 of Pub. L. 102–4, any veteran who served in Vietnam during the Vietnam Era and has one of the diseases on the presumptive list codified at 38 CFR 3.309(e), is presumed to have been exposed to herbicides. Under current law, the Vietnam Era is defined as January 9, 1962 through May 7, 1975, for the purposes of such presumptions. 38 U.S.C. 1116.)

Although Pub. L. 102–4 does not define ''credible,'' it does instruct the Secretary to ''take into consideration whether the results [of any study] are statistically significant, are capable of replication, and withstand peer review.'' Simply comparing the number of studies which report a positive relative risk to the number of studies which report a negative relative risk for a particular condition is not a valid method for determining whether the weight of evidence overall supports a finding that there is or is not a positive association between herbicide exposure and the subsequent development of the particular condition. Because of differences in statistical significance, confidence levels, control for confounding factors, bias, and other pertinent characteristics, some studies are clearly more credible than others, and the Secretary has given the more credible studies more weight in evaluating the overall weight of the evidence concerning specific diseases.

I. History of Agent Orange Presumptions

NAS issued its initial report, entitled ''Veterans and Agent Orange: Health Effects of Herbicides Used in Vietnam,'' (VAO) on July 27, 1993. The Secretary subsequently determined that a positive association exists between exposure to herbicides used in the Republic of Vietnam and the subsequent development of Hodgkin's disease, porphyria cutanea tarda, multiple myeloma, and certain respiratory cancers; and that there was no positive association between herbicide exposure and any other condition, other than chloracne, non-Hodgkin's lymphoma, and soft-tissue sarcomas, for which presumptions already existed. A notice of the diseases that the Secretary determined were not associated with exposure to herbicide agents was published on January 4, 1994 (see 59 FR 341–46).

NAS issued its second report, entitled ''Veterans and Agent Orange: Update 1996'' (Update 1996), on March 14, 1996. The Secretary subsequently determined that a positive association exists between exposure to herbicides used in the Republic of Vietnam and the subsequent development of prostate cancer and acute and subacute peripheral neuropathy in exposed persons. The Secretary further determined that there was no positive association between herbicide exposure and any other condition, other than those for which presumptions already existed. A notice of the diseases that the Secretary determined were not associated with exposure to herbicide agents was published on August 8, 1996 (see 61 FR 41442–49).

NAS issued a third report, entitled ''Veterans and Agent Orange: Update 1998'' (Update 1998), on February 11, 1999. The focus of this updated review was on new scientific studies published since the release of Update 1996 and updates of scientific studies previously reviewed. The Secretary determined that there was no positive association between herbicide exposure and any condition other than those for which presumptions already existed. A notice of this determination was published on November 2, 1999 (see 64 FR 59232–59243).

II. History of NAS Review of Type 2 Diabetes

In VAO, Update 1996, and Update 1998, NAS placed metabolic and digestive disorders (including Type 2 diabetes) in the category labeled ''Inadequate/Insufficient Evidence to Determine Whether an Association Exists.'' According to NAS, this means that the available studies are of insufficient quality, consistency, or statistical power to permit a conclusion regarding the presence or absence of an association. For example, studies fail to

control for confounding factors, have inadequate exposure assessments, or fail to address latency.

However, after NAS released Update 1998 the National Institute of Occupational Safety and Health (NIOSH) published a report that detects an association, though not a strong association, between Type 2 diabetes and dioxin exposure. The study does suggest a dose response relationship because of excess cases of Type 2 diabetes found in workers having the highest serum-lipid levels of dioxin (Calvert GM, Sweeney MH, Deddens J, Wall DK. 1999. Evaluation of Type 2 diabetes, Serum Glucose and Thyroid Function Among U.S. Workers Exposed to 2,3,7,8 tetrachlorodibenzo-p-dioxin. Occupational and Environmental Medicine 56:270–276). The Secretary concluded that the NIOSH study was potentially important enough that it warranted a full review by NAS as soon as possible, and he directed VA to amend its contract with NAS for the third biennial update to require a special report on herbicide exposure and Type 2 diabetes, as a separate deliverable.

In February 2000, before NAS released its report on herbicide exposure and Type 2 diabetes, the U.S. Air Force released data from its study of participants in operation Ranch Hand (the crews assigned to spray Agent Orange from aircraft in Vietnam) (AFHS. 2000. Air Force Health Study: An Epidemiologic Investigation of Health Effects in Air Force Personnel Following Exposure to Herbicides. 1997 Follow-up Examination Results. Brook AFB, TX: Air Force Research Laboratory. AFRL-HE-BR-TR–2000–02.) On April 10, 2000, VA asked NAS to include an analysis of the new Ranch Hand data in its report on Type 2 diabetes. NAS agreed to do so.

III. October 2000 NAS Review of Type 2 Diabetes

NAS issued its report, ''Veterans and Agent Orange: Herbicide/Dioxin Exposure and Type 2 Diabetes'' (VAO: Diabetes) on October 11, 2000. NAS concluded that ''there is limited/suggestive evidence of an association between exposure to the herbicides used in Vietnam or the contaminant dioxin and Type 2 diabetes.'' (''Type 2 diabetes'' is also referred to as ''Type II diabetes mellitus'' or ''adult-onset diabetes.'') The term ''limited/suggestive evidence'' means ''evidence is suggestive of an association between herbicides and the outcome, but limited because chance, bias, and confounding could not be ruled out with confidence.'' NAS based its conclusion on the totality of the scientific evidence on this issue, not one particular study. (VAO: Diabetes).

Mortality Studies on Type 2 Diabetes

In VAO: Diabetes, NAS noted that positive associations between herbicides and Type 2 diabetes are reported in many mortality studies. NAS stated that these may underestimate the incidence of Type 2 diabetes because: (1) It is not typically fatal; (2) its known complications, as opposed to Type 2 diabetes itself, may be more likely to be listed as the cause of death on the death certificate; and (3) contributory causes of death are not routinely recorded on death certificates. In one mortality study reviewed by NAS, people living near the site of a 1976 industrial accident involving dioxin were found to have a higher risk of death from Type 2 diabetes than a reference population, in all exposure zones in which deaths were recorded. (Pesatori AC, Zocchetti C, Guercilena S, Consonni D, Turrini D, Bertazzi, PA. 1998. Dioxin exposure and non-malignant health effects: a mortality study. Occupational and Environmental Medicine. 55:126–131.) Two studies of a group of workers exposed to TCDD at 12 U.S. plants found positive, but non-statistically significant associations between measures of exposure and notations of Type 2 diabetes on death certificates, although the later paper also found a significant negative trend between Type 2 diabetes mortality and cumulative TCDD exposure. (Steenland K, Nowlin S, Ryan B, Adams S. 1992. Use of multiple-cause mortality data in epidemiological analyses: US rate and proportion files developed by the National Institute for Occupational Safety and Health and the National Cancer Institute. American Journal of Epidemiology 136(7):855–862; Steenland K, Piacetelli L, Deddens J, Fingerhut M, Chang LI. 1999. Cancer, heart disease and diabetes in workers exposed to 2, 3, 7, 8-tetrachlorodibenzo-p-dioxin. Journal of the National Cancer Institute 91(9):779–786.) Another study, which examined workers who produced or sprayed phenoxy herbicides and chlorophenols, reported an elevated relative risk of mortality from Type 2 diabetes in exposed workers versus non-exposed referents. (Vena J, Boffetta P, Becher H, Benn T, Bueno-de-Mesquita HB, Coggon D, Colin D, Flesch-Janys D, Green L, Kauppinen T, Littorin M, Lynge E, Mathews JD, Neuberger M, Pearce N, Pesatori AC, Saracci R, Steenland K, Kogevinas M. 1998. Exposure to dioxin and nonneoplastic mortality in the expanded IARC international cohort study of phenoxy herbicide and chlorophenol production workers and sprayers. Environmental Health Perspectives 106 (Supplement 2):645–653.) In addition, earlier studies previously reviewed by NAS in and VAO, Update 1996, and Update 1998 showed an inconsistent but weakly positive association between exposure measures and Type 2 diabetes.

Morbidity Studies on Type 2 Diabetes

In VAO: Diabetes, NAS noted that, ''Positive associations are reported in most of the morbidity studies identified by the [NAS Committee to Review the Evidence Regarding the Link Between Exposure to Agent Orange and Diabetes].'' NAS discussed a number of epidemiological studies. In a study of a population near an Arkansas plant that manufactured pesticides, researchers found that insulin levels were significantly higher in the group with high dioxin levels. The study authors concluded that this was evidence that dioxin may cause insulin resistance. (Cranmer M, Louie S, Kennedy RH, Kern PA, Fonseca VA. 2000. Exposure to 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) is associated with hyperinsulinemia and insulin resistance. Toxicological Sciences 56(2): 431–436.) A survey of Australian Vietnam veterans found a statistically significant excess of self-reported Type 2 diabetes—2,391 cases were reported when 1,780 were expected. (Commonwealth Department of Veterans Affairs. 1998a. Morbidity of Vietnam Veterans: A Study of the Health of Australia's Vietnam Veteran Community. Volume 1: Male Vietnam Veterans Survey and Community Comparison Outcomes. Canberra: Commonwealth Department of Veterans Affairs.)

The 1999 NIOSH study (Calvert et al., 1999) reported an elevated incidence of Type 2 diabetes in individuals who had high levels of serum dioxin relative to others examined in that study. A study of the Ranch Hand comparison group, reported in 1999 and published in 2000, showed similar findings. (Longnecker MP, Michalek JE. 2000. Serum dioxin level in relation to Type 2 diabetes among Air Force veterans with background levels of exposure. Epidemiology 11(1):44–48.) The Air Force's subsequent analysis of Ranch Hand data (AFHS, 2000) showed almost identical Type 2 diabetes incidence in Ranch Hand and the matched comparison group. However, this study did show significant dose-response relationships between dioxin levels and Type 2 diabetes incidence, controlling for confounding variables.

Biological Plausibility

Regarding biologic plausibility, NAS concluded in VAO: Diabetes that animal, laboratory, and human studies constitute ''reasonable evidence that TCDD exposure could affect Type 2 diabetes risk in humans.'' This conclusion is based mainly on three studies. (Michalek JE. 1999. Oral presentation: Workshop on the Evidence Regarding a Link Between Exposure to Agent Orange and Diabetes. Washington, DC: Institute of Medicine, July 23; Longnecker MP and Michalek JE. 2000. Serum Dioxin Level in relation to Type 2 diabetes among Air Force veterans with background levels of exposure. Epidemiology 11(1):44–48; Cranmer M, Louie S, Kennedy RH, Kern PA, Fonseca VA. 2000. Exposure to 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) is associated with hyperinsulinemia and insulin resistance. Toxicological Sciences 56(2): 431–436.)

IV. The Secretary's Determination on Diabetes

NAS reviewed all known relevant scientific and medical articles published since Update 1998, and prior studies, as an integral part of the process that resulted in VAO: Diabetes. In VAO: Diabetes, NAS observed that, ''Although some of the risk estimates in the studies examined by the committee are not statistically significant and, individually, studies can be faulted for various methodological reasons, the accumulation of positive evidence is suggestive.''

After considering all of the evidence, the Secretary has determined that there is a positive association between exposure to herbicides and Type 2 diabetes and, therefore, a presumption of service connection is warranted.

V. Compliance With the Congressional Review Act, the Regulatory Flexibility Act, and Executive Order 12866

We estimate that the five-year cost of this proposed rule from appropriated funds would be $3.3 billion in benefits costs and $62 million in government operating expenses. Since it is likely that the adoption of the proposed rule may have an annual effect on the economy of $100 million or more, the Office of Management and Budget has designated this proposed rule as a major rule under the Congressional Review Act, 5 U.S.C. 802, and a significant regulatory action under Executive Order 12866, Regulatory Planning and Review. The following information is provided pursuant to E.O. 12866.

This proposed rule is necessary to comply with the Agent Orange Act of 1991, which requires VA to establish a presumption of service connection if the Secretary finds that there is a positive association between exposure to herbicides used in the Republic of Vietnam during the Vietnam era and the subsequent development of any particular disease. As explained above, the Acting Secretary has found that there is such an association regarding Type 2 diabetes. There are no feasible alternatives to this proposed rule, since the Agent Orange Act of 1991 requires the Secretary to promulgate it once he finds the positive association described above. The adoption of the proposed rule would not interfere with state, local or tribal governments in the exercise of their governmental functions.

Benefits Costs

Historical statistics indicate that the total number of veterans who served in the Republic of Vietnam or its surrounding waters was about 2.6 million. We estimate that about 2.3 million of these veterans are alive today. Using information gained from VAO: Diabetes and VA's Office of Planning and Analysis, VA applied a prevalence rate of 9% to the current population to determine the number of veterans who might have Type 2 diabetes today. VA assumes that over five years, about 90% of these same veterans would file a diabetes-related claim. We expect that 8 out of 10 claims will be made by first time applicants (original) and that 2 out of 10 will come from veterans already service connected for some other issue (reopened). The average monthly award made on account of diabetes or its ancillary conditions for original and reopened claims is estimated to be $462 and $786, respectively. These figures are based on average benefits to current beneficiaries for all conditions and include dependents' benefits and unemployability benefits where applicable. A moderate number of DIC and burial claims have also been factored into this estimate.

VA estimates the cumulative totals of benefits awards to claimants for years 2001–2005 as follows: 10,199, 80,526, 129,988, 159,198 and 178,356. Benefits costs (in $ million) for years 2001–2005 are as follows: $16.6, $303, $720.1, $1,010.7, and $1,205.3, for a total cost of $3.3 billion over five years. This cost estimate also provides for a nominal number of DIC payments and burial awards. Anticipated cost-of-living allowances (COLA's), per current economic assumptions, were factored into this estimate; however, no retroactive payments were considered.

Administrative Costs.

The administrative workload caused by this proposed rule is expected to be 13,361 claims filed in 2001 and more than 220,000 over five years. Full time employee resources devoted to processing claims in years one through five would be 128, 378, 311, 185, and 123, respectively. Administrative workloads assume that not all claims would be granted; it is probable that diabetes related claims will be received from veterans who never served in the Republic of Vietnam. GOE costs (in $ million) for years 2001–2005 are as follows: $6.4, $18.6, $16.5, $11.9, and $8.2, for a total GOE cost of $62 million over five years.

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. The reason for this certification is that these amendments would not directly affect any small entities. Only VA beneficiaries could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), these amendments are exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

The Catalog of Federal Domestic Assistance program numbers are 64.100, 64.101, 64.104, 64.105, 64.106, 64.109, and 64.110.

List of Subjects in 38 CFR Part 3

Administrative practice and procedure, Claims, Disability benefits, Health care, Pensions, Veterans, Vietnam.

Approved: December 6, 2000.

Hershel W. Gober,

Acting Secretary of Veterans Affairs.

For the reasons set forth in the preamble, 38 CFR part 3 is proposed to be amended as follows:

PART 3—ADJUDICATION

Subpart A—Pension, Compensation, and Dependency and Indemnity Compensation

1. The authority citation for part 3, subpart A continues to read as follows:

Authority: 38 U.S.C. 501(a), unless otherwise noted.

2. In § 3.309, paragraph (e), the listing of diseases is amended by adding ''Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)'' between ''Chloracne or other acneform disease consistent with chloracne'' and ''Hodgkin's disease'' to read as follows:

§ 3.309 Diseases subject to presumptive service connection.

* * * * *

(e) * * *

Type 2 diabetes (also known as Type II diabetes mellitus or adult-onset diabetes)

* * * * *

[FR Doc. 01–685 Filed 1–8–01; 8:45 am]

BILLING CODE 8320–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[FRL–6931–7]

National Priorities List for Uncontrolled Hazardous Waste Sites, Proposed Rule No. 35

AGENCY: Environmental Protection Agency.

ACTION: Proposed rule.

SUMMARY: The Comprehensive Environmental Response, Compensation, and Liability Act (''CERCLA'' or ''the Act''), requires that the National Oil and Hazardous Substances Pollution Contingency Plan (''NCP'') include a list of national priorities among the known releases or threatened releases of hazardous substances, pollutants, or contaminants throughout the United States. The National Priorities List (''NPL'') constitutes this list. The NPL is intended primarily to guide the Environmental Protection Agency (''EPA'' or ''the Agency'') in determining which sites warrant further investigation to assess the nature and extent of public health and environmental risks associated with the site and to determine what CERCLA-financed remedial action(s), if any, may be appropriate. This proposed rule proposes to add five new sites to the NPL, all to the General Superfund Section of the NPL. (Please note that one of the sites is being reproposed to the NPL.)

DATES: Comments regarding any of these proposed listings must be submitted (postmarked) on or before March 12, 2001.

ADDRESSES: By Postal Mail: Mail original and three copies of comments (no facsimiles or tapes) to Docket Coordinator, Headquarters; U.S. Environmental Protection Agency; CERCLA Docket Office; (Mail Code 5201G); 1200 Pennsylvania Avenue, NW., Washington, DC 20460.

By Express Mail or Courier: Send original and three copies of comments (no facsimiles or tapes) to Docket Coordinator, Headquarters; U.S. Environmental Protection Agency; CERCLA Docket Office; 1235 Jefferson Davis Highway; Crystal Gateway #1, First Floor; Arlington, VA 22202.

By E-Mail: Comments in ASCII format only may be mailed directly to *superfund.docket@epa.gov.* E-mailed comments must be followed up by an original and three copies sent by mail or express mail.

For additional Docket addresses and further details on their contents, see section II, ''Public Review/Public Comment,'' of the Supplementary Information portion of this preamble.

FOR FURTHER INFORMATION CONTACT: Yolanda Singer, phone (703) 603–8835, State, Tribal and Site Identification Center, Office of Emergency and Remedial Response (Mail Code 5204G); U.S. Environmental Protection Agency; 1200 Pennsylvania Avenue, NW., Washington, DC 20460; or the Superfund Hotline, Phone (800) 424–9346 or (703) 412–9810 in the Washington, DC metropolitan area.

SUPPLEMENTARY INFORMATION:

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I. Background

A. What Are CERCLA and SARA?

In 1980, Congress enacted the Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. 9601–9675 (''CERCLA'' or ''the Act''), in response to the dangers of uncontrolled releases of hazardous substances. CERCLA was amended on October 17, 1986, by the Superfund Amendments and Reauthorization Act (''SARA''), Pub. L. 99–499, 100 Stat. 1613 *et seq.*

B. What Is the NCP?

To implement CERCLA, EPA promulgated the revised National Oil and Hazardous Substances Pollution Contingency Plan (''NCP''), 40 CFR part 300, on July 16, 1982 (47 FR 31180), pursuant to CERCLA section 105 and Executive Order 12316 (46 FR 42237, August 20, 1981). The NCP sets guidelines and procedures for responding to releases and threatened releases of hazardous substances, pollutants, or contaminants under CERCLA. EPA has revised the NCP on several occasions. The most recent comprehensive revision was on March 8, 1990 (55 FR 8666).

As required under section 105(a)(8)(A) of CERCLA, the NCP also includes ''criteria for determining priorities among releases or threatened releases throughout the United States for the purpose of taking remedial action and, to the extent practicable, taking into account the potential

urgency of such action for the purpose of taking removal action.'' ''Removal'' actions are defined broadly and include a wide range of actions taken to study, clean up, prevent or otherwise address releases and threatened releases (42 U.S.C. 9601(23)).

C. What Is the National Priorities List (NPL)?

The NPL is a list of national priorities among the known or threatened releases of hazardous substances, pollutants, or contaminants throughout the United States. The list, which is appendix B of the NCP (40 CFR part 300), was required under section 105(a)(8)(B) of CERCLA, as amended by SARA. Section 105(a)(8)(B) defines the NPL as a list of ''releases'' and the highest priority ''facilities'' and requires that the NPL be revised at least annually. The NPL is intended primarily to guide EPA in determining which sites warrant further investigation to assess the nature and extent of public health and environmental risks associated with a release of hazardous substances. The NPL is only of limited significance, however, as it does not assign liability to any party or to the owner of any specific property. Neither does placing a site on the NPL mean that any remedial or removal action necessarily need be taken. See Report of the Senate Committee on Environment and Public Works, Senate Rep. No. 96–848, 96th Cong., 2d Sess. 60 (1980), 48 FR 40659 (September 8, 1983).

For purposes of listing, the NPL includes two sections, one of sites that are generally evaluated and cleaned up by EPA (the ''General Superfund Section''), and one of sites that are owned or operated by other Federal agencies (the ''Federal Facilities Section''). With respect to sites in the Federal Facilities section, these sites are generally being addressed by other Federal agencies. Under Executive Order 12580 (52 FR 2923, January 29, 1987) and CERCLA section 120, each Federal agency is responsible for carrying out most response actions at facilities under its own jurisdiction, custody, or control, although EPA is responsible for preparing an HRS score and determining whether the facility is placed on the NPL. EPA generally is not the lead agency at Federal Facilities Section sites, and its role at such sites is accordingly less extensive than at other sites.

D. How Are Sites Listed on the NPL?

There are three mechanisms for placing sites on the NPL for possible remedial action (see 40 CFR 300.425(c) of the NCP): (1) A site may be included on the NPL if it scores sufficiently high on the Hazard Ranking System (''HRS''), which EPA promulgated as an appendix A of the NCP (40 CFR part 300). The HRS serves as a screening device to evaluate the relative potential of uncontrolled hazardous substances to pose a threat to human health or the environment. On December 14, 1990 (55 FR 51532), EPA promulgated revisions to the HRS partly in response to CERCLA section 105(c), added by SARA. The revised HRS evaluates four pathways: Ground water, surface water, soil exposure, and air. As a matter of Agency policy, those sites that score 28.50 or greater on the HRS are eligible for the NPL; (2) Each State may designate a single site as its top priority to be listed on the NPL, regardless of the HRS score. This mechanism, provided by the NCP at 40 CFR 300.425(c)(2) requires that, to the extent practicable, the NPL include within the 100 highest priorities, one facility designated by each State representing the greatest danger to public health, welfare, or the environment among known facilities in the State (see 42 U.S.C. 9605(a)(8)(B)); (3) The third mechanism for listing, included in the NCP at 40 CFR 300.425(c)(3), allows certain sites to be listed regardless of their HRS score, if all of the following conditions are met:

- The Agency for Toxic Substances and Disease Registry (ATSDR) of the U.S. Public Health Service has issued a health advisory that recommends dissociation of individuals from the release.
- EPA determines that the release poses a significant threat to public health.
- EPA anticipates that it will be more cost-effective to use its remedial authority than to use its removal authority to respond to the release.

EPA promulgated an original NPL of 406 sites on September 8, 1983 (48 FR 40658). The NPL has been expanded since then, most recently on December 1, 2000 (65 FR 75179).

E. What Happens to Sites on the NPL?

A site may undergo remedial action financed by the Trust Fund established under CERCLA (commonly referred to as the ''Superfund'') only after it is placed on the NPL, as provided in the NCP at 40 CFR 300.425(b)(1). (''Remedial actions'' are those ''consistent with permanent remedy, taken instead of or in addition to removal actions. * * *'' 42 U.S.C. 9601(24).) However, under 40 CFR 300.425(b)(2) placing a site on the NPL ''does not imply that monies will be expended.'' EPA may pursue other appropriate authorities to remedy the releases, including enforcement action under CERCLA and other laws.

F. How Are Site Boundaries Defined?

The NPL does not describe releases in precise geographical terms; it would be neither feasible nor consistent with the limited purpose of the NPL (to identify releases that are priorities for further evaluation), for it to do so.

Although a CERCLA ''facility'' is broadly defined to include any area where a hazardous substance release has ''come to be located'' (CERCLA section 101(9)), the listing process itself is not intended to define or reflect the boundaries of such facilities or releases. Of course, HRS data (if the HRS is used to list a site) upon which the NPL placement was based will, to some extent, describe the release(s) at issue. That is, the NPL site would include all releases evaluated as part of that HRS analysis.

When a site is listed, the approach generally used to describe the relevant release(s) is to delineate a geographical area (usually the area within an installation or plant boundaries) and identify the site by reference to that area. As a legal matter, the site is not coextensive with that area, and the boundaries of the installation or plant are not the ''boundaries'' of the site. Rather, the site consists of all contaminated areas within the area used to identify the site, as well as any other location to which contamination from that area has come to be located, or from which that contamination came.

In other words, while geographic terms are often used to designate the site (*e.g.,* the ''Jones Co. plant site'') in terms of the property owned by a particular party, the site properly understood is not limited to that property (*e.g.,* it may extend beyond the property due to contaminant migration), and conversely may not occupy the full extent of the property (*e.g.,* where there are uncontaminated parts of the identified property, they may not be, strictly speaking, part of the ''site''). The ''site'' is thus neither equal to nor confined by the boundaries of any specific property that may give the site its name, and the name itself should not be read to imply that this site is coextensive with the entire area within the property boundary of the installation or plant. The precise nature and extent of the site are typically not known at the time of listing. Also, the site name is merely used to help identify the geographic location of the contamination. For example, the ''Jones Co. plant site,'' does not imply that the Jones company

is responsible for the contamination located on the plant site.

EPA regulations provide that the ''nature and extent of the problem presented by the release'' will be determined by a Remedial Investigation/Feasibility Study (''RI/FS'') as more information is developed on site contamination (40 CFR 300.5). During the RI/FS process, the release may be found to be larger or smaller than was originally thought, as more is learned about the source(s) and the migration of the contamination. However, this inquiry focuses on an evaluation of the threat posed; the boundaries of the release need not be exactly defined. Moreover, it generally is impossible to discover the full extent of where the contamination ''has come to be located'' before all necessary studies and remedial work are completed at a site. Indeed, the boundaries of the contamination can be expected to change over time. Thus, in most cases, it may be impossible to describe the boundaries of a release with absolute certainty.

Further, as noted above, NPL listing does not assign liability to any party or to the owner of any specific property. Thus, if a party does not believe it is liable for releases on discrete parcels of property, supporting information can be submitted to the Agency at any time after a party receives notice it is a potentially responsible party.

For these reasons, the NPL need not be amended as further research reveals more information about the location of the contamination or release.

G. How Are Sites Removed From the NPL?

EPA may delete sites from the NPL where no further response is appropriate under Superfund, as explained in the NCP at 40 CFR 300.425(e). This section also provides that EPA shall consult with states on proposed deletions and shall consider whether any of the following criteria have been met: (i) Responsible parties or other persons have implemented all appropriate response actions required; (ii) All appropriate Superfund-financed response has been implemented and no further response action is required; or (iii) The remedial investigation has shown the release poses no significant threat to public health or the environment, and taking of remedial measures is not appropriate. As of January 3, 2001, the Agency has deleted 229 sites from the NPL.

H. Can Portions of Sites Be Deleted From the NPL as They Are Cleaned Up?

In November 1995, EPA initiated a new policy to delete portions of NPL sites where cleanup is complete (60 FR 55465, November 1, 1995). Total site cleanup may take many years, while portions of the site may have been cleaned up and available for productive use. As of January 3, 2001, EPA has deleted portions of 21 sites.

I. What Is the Construction Completion List (CCL)?

EPA also has developed an NPL construction completion list (''CCL'') to simplify its system of categorizing sites and to better communicate the successful completion of cleanup activities (58 FR 12142, March 2, 1993). Inclusion of a site on the CCL has no legal significance.

Sites qualify for the CCL when: (1) Any necessary physical construction is complete, whether or not final cleanup levels or other requirements have been achieved; (2) EPA has determined that the response action should be limited to measures that do not involve construction (*e.g.,* institutional controls); or (3) The site qualifies for deletion from the NPL.

As of January 3, 2001, there are a total of 759 sites on the CCL. For the most up-to-date information on the CCL, see EPA's Internet site at *http://www.epa.gov/superfund.*

II. Public Review/Public Comment

A. Can I Review the Documents Relevant to This Proposed Rule?

Yes, documents that form the basis for EPA's evaluation and scoring of the sites in this rule are contained in dockets located both at EPA Headquarters in Washington, DC and in the Regional offices.

B. How Do I Access the Documents?

You may view the documents, by appointment only, in the Headquarters or the Regional dockets after the appearance of this proposed rule. The hours of operation for the Headquarters docket are from 9 a.m. to 4 p.m., Monday through Friday excluding Federal holidays. Please contact the Regional dockets for hours.

Following is the contact information for the EPA Headquarters docket: Docket Coordinator, Headquarters, U.S. EPA CERCLA Docket Office, Crystal Gateway #1, 1st Floor, 1235 Jefferson Davis Highway, Arlington, VA 22202, 703/603–9232. (Please note this is a visiting address only. Mail comments to EPA Headquarters as detailed at the beginning of this preamble.)

The contact information for the Regional dockets is as follows:

Ellen Culhane, Region 1 (CT, ME, MA, NH, RI, VT), U.S. EPA, Records Center, Mailcode HSC, One Congress Street, Suite 1100, Boston, MA 02114–2023; 617/918–1225

Ben Conetta, Region 2 (NJ, NY, PR, VI), U.S. EPA, 290 Broadway, New York, NY 10007–1866; 212/637–4435

Dawn Shellenberger (GCI), Region 3 (DE, DC, MD, PA, VA, WV), U.S. EPA, Library, 1650 Arch Street, Mailcode 3PM52, Philadelphia, PA 19103; 215/814–5364

Joellen O'Neill, Region 4 (AL, FL, GA, KY, MS, NC, SC, TN), U.S. EPA, 61 Forsyth Street, SW, 9th floor, Atlanta, GA 30303; 404/562–8127

Janet Pfundheller, Region 5 (IL, IN, MI, MN, OH, WI), U.S. EPA, Records Center, Superfund Division SMR–7J, Metcalfe Federal Building, 77 West Jackson Boulevard, Chicago, IL 60604; 312/353–5821

Brenda Cook, Region 6 (AR, LA, NM, OK, TX), U.S. EPA, 1445 Ross Avenue, Mailcode 6SF–RA, Dallas, TX 75202–2733; 214/665–7436

Michelle Quick, Region 7 (IA, KS, MO, NE), U.S. EPA, 901 North 5th Street, Kansas City, KS 66101; 913/551–7335

David Williams, Region 8 (CO, MT, ND, SD, UT, WY), U.S. EPA, 999 18th Street, Suite 500, Mailcode 8EPR–SA, Denver, CO 80202–2466; 303/312–6757

Carolyn Douglas, Region 9 (AZ, CA, HI, NV, AS, GU), U.S. EPA, 75 Hawthorne Street, San Francisco, CA 94105; 415/744–2343

Robert Phillips, Region 10 (AK, ID, OR, WA), U.S. EPA, 11th Floor, 1200 6th Avenue, Mail Stop ECL–110, Seattle, WA 98101; 206/553–6699

You may also request copies from EPA Headquarters or the Regional dockets. An informal request, rather than a formal written request under the Freedom of Information Act, should be the ordinary procedure for obtaining copies of any of these documents.

C. What Documents Are Available for Public Review at the Headquarters Docket?

The Headquarters docket for this rule contains: HRS score sheets for the proposed sites; a Documentation Record for the sites describing the information used to compute the score; information for any sites affected by particular statutory requirements or EPA listing policies; and a list of documents referenced in the Documentation Record.

D. What Documents Are Available for Public Review at the Regional Dockets?

The Regional dockets for this rule contain all of the information in the Headquarters docket, plus, the actual reference documents containing the data principally relied upon and cited by EPA in calculating or evaluating the HRS score for the sites. These reference documents are available only in the Regional dockets.

E. How Do I Submit My Comments?

Comments must be submitted to EPA Headquarters as detailed at the beginning of this preamble in the ''Addresses'' section. Please note that the addresses differ according to method of delivery. There are two different addresses that depend on whether comments are sent by express mail or by postal mail.

F. What Happens to My Comments?

EPA considers all comments received during the comment period. Significant comments will be addressed in a support document that EPA will publish concurrently with the **Federal Register** document if, and when, the site is listed on the NPL.

G. What Should I Consider When Preparing My Comments?

Comments that include complex or voluminous reports, or materials prepared for purposes other than HRS scoring, should point out the specific information that EPA should consider and how it affects individual HRS factor values or other listing criteria (*Northside Sanitary Landfill* v. *Thomas*, 849 F.2d 1516 (D.C. Cir. 1988)). EPA will not address voluminous comments that are not specifically cited by page number and referenced to the HRS or other listing criteria. EPA will not address comments unless they indicate which component of the HRS documentation record or what particular point in EPA's stated eligibility criteria is at issue.

H. Can I Submit Comments After the Public Comment Period Is Over?

Generally, EPA will not respond to late comments. EPA can only guarantee that it will consider those comments postmarked by the close of the formal comment period. EPA has a policy of not delaying a final listing decision solely to accommodate consideration of late comments.

I. Can I View Public Comments Submitted by Others?

During the comment period, comments are placed in the Headquarters docket and are available to the public on an ''as received'' basis. A complete set of comments will be available for viewing in the Regional docket approximately one week after the formal comment period closes.

J. Can I Submit Comments Regarding Sites Not Currently Proposed to the NPL?

In certain instances, interested parties have written to EPA concerning sites which were not at that time proposed to the NPL. If those sites are later proposed to the NPL, parties should review their earlier concerns and, if still appropriate, resubmit those concerns for consideration during the formal comment period. Site-specific correspondence received prior to the period of formal proposal and comment will not generally be included in the docket.

III. Contents of This Proposed Rule

A. Proposed Additions to the NPL

With today's proposed rule, EPA is proposing to add five new sites to the NPL; all to the General Superfund Section of the NPL. (Please note that the Cooper Drum site in California is being reproposed.) The sites in this proposed rulemaking are being proposed based on HRS scores of 28.50 or above. The sites are presented in Table 1 which follows this preamble.

B. Status of NPL

Currently, the NPL consists of 1,229 final sites; 1,069 in the General Superfund Section and 160 in the Federal Facilities Section. With this proposal of 5 new sites, there are now 67 sites proposed and awaiting final agency action, 61 in the General Superfund Section and six in the Federal Facilities Section. Final and proposed sites now total 1,296. (These numbers reflect the status of sites as of January 3, 2001. Site deletions occurring after this date may affect these numbers at time of publication in the **Federal Register**.)

IV. Executive Order 12866

A. What Is Executive Order 12866?

Under Executive Order 12866, (58 FR 51735 (October 4, 1993)) the Agency must determine whether a regulatory action is ''significant'' and therefore subject to OMB review and the requirements of the Executive Order. The Order defines ''significant regulatory action'' as one that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

B. Is This Proposed Rule Subject to Executive Order 12866 Review?

No, the Office of Management and Budget (OMB) has exempted this regulatory action from Executive Order 12866 review.

V. Unfunded Mandates

A. What Is the Unfunded Mandates Reform Act (UMRA)?

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal Agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. Under section 202 of the UMRA, EPA generally must prepare a written statement, including a cost-benefit analysis, for proposed and final rules with ''Federal mandates'' that may result in expenditures by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year. Before EPA promulgates a rule for which a written statement is needed, section 205 of the UMRA generally requires EPA to identify and consider a reasonable number of regulatory alternatives and adopt the least costly, most cost-effective, or least burdensome alternative that achieves the objectives of the rule. The provisions of section 205 do not apply when they are inconsistent with applicable law. Moreover, section 205 allows EPA to adopt an alternative other than the least costly, most cost-effective, or least burdensome alternative if the Administrator publishes with the final rule an explanation why that alternative was not adopted. Before EPA establishes any regulatory requirements that may significantly or uniquely affect small governments, including tribal governments, it must have developed under section 203 of the UMRA a small government agency plan. The plan must provide for notifying potentially affected small governments, enabling officials of affected small governments to have meaningful and timely input in

the development of EPA regulatory proposals with significant Federal intergovernmental mandates, and informing, educating, and advising small governments on compliance with the regulatory requirements.

B. Does UMRA Apply to This Proposed Rule?

No, EPA has determined that this rule does not contain a Federal mandate that may result in expenditures of $100 million or more for State, local, and tribal governments in the aggregate, or by the private sector in any one year. This rule will not impose any federal intergovernmental mandate because it imposes no enforceable duty upon State, tribal or local governments. Listing a site on the NPL does not itself impose any costs. Listing does not mean that EPA necessarily will undertake remedial action. Nor does listing require any action by a private party or determine liability for response costs. Costs that arise out of site responses result from site-specific decisions regarding what actions to take, not directly from the act of listing a site on the NPL.

For the same reasons, EPA also has determined that this rule contains no regulatory requirements that might significantly or uniquely affect small governments. In addition, as discussed above, the private sector is not expected to incur costs exceeding $100 million. EPA has fulfilled the requirement for analysis under the Unfunded Mandates Reform Act.

VI. Effect on Small Businesses

A. What Is the Regulatory Flexibility Act?

Pursuant to the Regulatory Flexibility Act (5 U.S.C. 601 et seq., as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA) of 1996) whenever an agency is required to publish a notice of rulemaking for any proposed or final rule, it must prepare and make available for public comment a regulatory flexibility analysis that describes the effect of the rule on small entities (i.e., small businesses, small organizations, and small governmental jurisdictions). However, no regulatory flexibility analysis is required if the head of an agency certifies the rule will not have a significant economic impact on a substantial number of small entities. SBREFA amended the Regulatory Flexibility Act to require Federal agencies to provide a statement of the factual basis for certifying that a rule will not have a significant economic impact on a substantial number of small entities.

B. Has EPA Conducted a Regulatory Flexibility Analysis for This Rule?

No. While this rule proposes to revise the NPL, an NPL revision is not a typical regulatory change since it does not automatically impose costs. As stated above, adding sites to the NPL does not in itself require any action by any party, nor does it determine the liability of any party for the cost of cleanup at the site. Further, no identifiable groups are affected as a whole. As a consequence, impacts on any group are hard to predict. A site's inclusion on the NPL could increase the likelihood of adverse impacts on responsible parties (in the form of cleanup costs), but at this time EPA cannot identify the potentially affected businesses or estimate the number of small businesses that might also be affected.

The Agency does expect that placing the sites in this proposed rule on the NPL could significantly affect certain industries, or firms within industries, that have caused a proportionately high percentage of waste site problems. However, EPA does not expect the listing of these sites to have a significant economic impact on a substantial number of small businesses.

In any case, economic impacts would occur only through enforcement and cost-recovery actions, which EPA takes at its discretion on a site-by-site basis. EPA considers many factors when determining enforcement actions, including not only a firm's contribution to the problem, but also its ability to pay. The impacts (from cost recovery) on small governments and nonprofit organizations would be determined on a similar case-by-case basis.

For the foregoing reasons, I hereby certify that this proposed rule, if promulgated, will not have a significant economic impact on a substantial number of small entities. Therefore, this proposed regulation does not require a regulatory flexibility analysis.

VII. National Technology Transfer and Advancement Act

A. What Is the National Technology Transfer and Advancement Act?

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), directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (*e.g.*, materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

B. Does the National Technology Transfer and Advancement Act Apply to This Proposed Rule?

No. This proposed rulemaking does not involve technical standards. Therefore, EPA did not consider the use of any voluntary consensus standards.

VIII. Executive Order 12898

A. What Is Executive Order 12898?

Under Executive Order 12898, ''Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations,'' as well as through EPA's April 1995, ''Environmental Justice Strategy, OSWER Environmental Justice Task Force Action Agenda Report,'' and National Environmental Justice Advisory Council, EPA has undertaken to incorporate environmental justice into its policies and programs. EPA is committed to addressing environmental justice concerns, and is assuming a leadership role in environmental justice initiatives to enhance environmental quality for all residents of the United States. The Agency's goals are to ensure that no segment of the population, regardless of race, color, national origin, or income, bears disproportionately high and adverse human health and environmental effects as a result of EPA's policies, programs, and activities, and all people live in clean and sustainable communities.

B. Does Executive Order 12898 Apply to This Proposed Rule?

No. While this rule proposes to revise the NPL, no action will result from this proposal that will have disproportionately high and adverse human health and environmental effects on any segment of the population.

IX. Executive Order 13045

A. What Is Executive Order 13045?

Executive Order 13045: ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997) applies to any rule that: (1) Is determined to be ''economically significant'' as defined under E.O. 12866, and (2) concerns an environmental health or safety risk that EPA has reason to believe may have a disproportionate effect on children. If the regulatory action meets both criteria, the Agency must evaluate the

environmental health or safety effects of the planned rule on children, and explain why the planned regulation is preferable to other potentially effective and reasonably feasible alternatives considered by the Agency.

B. Does Executive Order 13045 Apply to This Proposed Rule?

This proposed rule is not subject to E.O. 13045 because it is not an economically significant rule as defined by E.O. 12866, and because the Agency does not have reason to believe the environmental health or safety risks addressed by this proposed rule present a disproportionate risk to children.

X. Paperwork Reduction Act

A. What Is the Paperwork Reduction Act?

According to the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information that requires OMB approval under the PRA, unless it has been approved by OMB and displays a currently valid OMB control number. The OMB control numbers for EPA's regulations, after initial display in the preamble of the final rules, are listed in 40 CFR part 9. The information collection requirements related to this action have already been approved by OMB pursuant to the PRA under OMB control number 2070–0012 (EPA ICR No. 574).

B. Does the Paperwork Reduction Act Apply to This Proposed Rule?

No. EPA has determined that the PRA does not apply because this rule does not contain any information collection requirements that require approval of the OMB.

XI. Executive Orders on Federalism

A. What Are The Executive Orders on Federalism and Are They Applicable to This Proposed Rule?

Executive Order 13132, entitled ''Federalism'' (64 FR 43255, August 10, 1999), 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.''

Under Section 6 of Executive Order 13132, EPA may not issue a regulation that has federalism implications, that imposes substantial direct compliance costs, and that is not required by statute, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by State and local governments, or EPA consults with State and local officials early in the process of developing the proposed regulation. EPA also may not issue a regulation that has federalism implications and that preempts State law, unless the Agency consults with State and local officials early in the process of developing the proposed regulation.

This proposed rule does not have federalism implications. It 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. Thus, the requirements of section 6 of the Executive Order do not apply to this rule.

XII. Executive Order 13084

What is Executive Order 13084 and Is It Applicable to this Proposed Rule?

Under Executive Order 13084, EPA may not issue a regulation that is not required by statute, that significantly or uniquely affects the communities of Indian tribal governments, and that imposes substantial direct compliance costs on those communities, unless the Federal government provides the funds necessary to pay the direct compliance costs incurred by the tribal governments, or EPA consults with those governments. If EPA complies by consulting, Executive Order 13084 requires EPA to provide to the Office of Management and Budget, in a separately identified section of the preamble to the rule, a description of the extent of EPA's prior consultation with representatives of affected tribal governments, a summary of the nature of their concerns, and a statement supporting the need to issue the regulation. In addition, Executive Order 13084 requires EPA to develop an effective process permitting elected officials and other representatives of Indian tribal governments ''to provide meaningful and timely input in the development of regulatory policies on matters that significantly or uniquely affect their communities.''

This proposed rule does not significantly or uniquely affect the communities of Indian tribal governments because it does not significantly or uniquely affect their communities. Accordingly, the requirements of section 3(b) of Executive Order 13084 do not apply to this proposed rule.

TABLE 1.—NATIONAL PRIORITIES LIST PROPOSED RULE NO. 35, GENERAL SUPERFUND SECTION

State	Site name	City/county
CA	Cooper Drum Company.	South Gate
NJ	Quanta Resources.	Edgewater
NM	Griggs & Walnut Ground Water Plume.	Las Cruces
NY	Shenandoah Road Ground Water Contamination.	East Fishkill
NC	Barber Orchard...	Waynesville

Number of Sites Proposed to General Superfund Section: 5.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous waste, Intergovernmental relations, Natural resources, Oil pollution, penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(c)(2); 42 U.S.C. 9601–9657; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

Dated: January 3, 2001.

Timothy Fields, Jr.,

Assistant Administrator, Office of Solid Waste and Emergency Response.

[FR Doc. 01–563 Filed 1–10–01; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Part 66

[USCG–1998–3798]

RIN 2115–AF13

Numbering of Undocumented Barges

AGENCY: Coast Guard, DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Coast Guard proposes to promulgate statutory requirements for numbering and marking barges in reserved part 66 of Title 46, Code of Federal Regulations. This rulemaking

will establish a statutorily required numbering system for undocumented barges more than 100 gross tons operating on the navigable waters of the United States. A barge numbering system will help identify parties responsible for the illegal abandonment of barges and prevent future marine pollution from abandoned barges.

DATES: Comments and related material must reach the Docket Management Facility on or before April 11, 2001. Comments sent to the Office of Management and Budget (OMB) on collection of information must reach OMB on or before March 12, 2001.

ADDRESSES: To make sure your comments and related material are not entered more than once in the docket, please submit them by only one of the following means:

(1) By mail to the Docket Management Facility, USCG–1998–3798, U.S. Department of Transportation, room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001.

(2) By delivery to room PL–401 on the Plaza level of the Nassif Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

(3) By fax to the Docket Management Facility at 202–493–2251.

(4) Electronically through the Web Site for the Docket Management System at http://dms.dot.gov.

You must also mail comments on collection of information to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725 17th Street, NW., Washington, DC 20503, ATTN: Desk Officer, U.S. Coast Guard.

The Docket Management Facility maintains the public docket for this rulemaking. Comments and material received from the public, as well as documents mentioned in this preamble as being available in the docket, will become part of this docket and will be available for inspection or copying at room PL–401 on the Plaza level of the Nassif Building, 400 Seventh Street SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also find this docket on the Internet at *http://dms.dot.gov.*

FOR FURTHER INFORMATION CONTACT: For questions on this proposed rule, call LCDR Robyn MacGregor, Project Manager, Office of Waterways Security and Safety (G–MWP), Coast Guard, telephone 202–267–0483. For questions on viewing or submitting material to the docket, call Dorothy Beard, Chief, Dockets, Department of Transportation, telephone 202–366–9329.

SUPPLEMENTARY INFORMATION:

Request for Comments

We encourage you to participate in this rulemaking by submitting comments and related material. If you do so, please include your name and address, identify the docket number for this rulemaking (USCG–1998–3798), indicate the specific section of this document to which each comment applies, and give the reason for each comment. You may submit your comments and material by mail, hand delivery, fax, or electronic means to the Docket Management Facility at the address under **ADDRESSES**; but please submit your comments and material by only one means. If you submit them by mail or hand delivery, submit them in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you submit them by mail and would like to know they reached the Facility, please enclose a stamped, self-addressed postcard or envelope. We will consider all comments and material received during the comment period. We may change this proposed rule in view of them.

Public Meeting

The Coast Guard plans no public meeting. You may request a public meeting by submitting a comment requesting one to the address under **ADDRESSES**. The request should include the reasons why a meeting would be beneficial. If the Coast Guard determines that a meeting should be held, we will announce the time and place in a later notice in the **Federal Register**.

Background and Purpose

According to a 1992 Government Accounting Office (GAO) report on abandoned vessels, nearly 1,300 vessels were abandoned in the navigable waters of the United States. Almost 600 of the abandonments were barges. According to the same report, between the years of 1988 and 1992, 82 water pollution incidents occurred which originated from abandoned vessels, 37 of which required cleanup operations. During that period, the Coast Guard conducted oil removal operations for 14 additional vessels that posed a potential threat of discharge or release. The combined cost of these operations was $4.4 million, with $2.5 million spent on two separate removal operations from the same vessel, an abandoned barge located in Empire, Louisiana.

During the 1988 to 1992 period, barges that used inland waterways were exempted from vessel documentation. Additionally, there were no Federal laws prohibiting vessel owners from abandoning vessels. Therefore, it was often very difficult to identify and locate owners of abandoned vessels. In many cases where ownership was determined, owners were unable to remove their abandoned vessels for a variety of reasons (*e.g.*, deceased, bankrupt, etc.). Without a process linking abandoned vessels to responsible parties, the government has little chance of recovering vessel removal or pollution response costs.

In an annual summary report on abandoned vessels submitted in 1997 by the Captains of the Ports (COTP), each COTP documented the number of abandoned vessels within their geographic areas of responsibility. The report stated that 2,697 abandoned vessels existed along our navigable waters. Of this total, 1,010 were barges.

Based on the GAO Report, the annual COTP summary report with supplementary Coast Guard testimony, industry representatives, and others, Congress passed the Abandoned Barge Act of 1992 (Pub. L. 102–587, sections 5301–05) (''the Act''). During passage of the Act, Congress noted that abandoned barges are often used for the illegal disposal of hazardous cargo, waste, and petroleum products. This illegal disposal can lead to actual or potential pollution incidents. To prevent these incidents, the Act added a new chapter 47 to title 46 of the United States Code that prohibits abandoning barges in the navigable waters of the United States. The Act also amended 46 U.S.C. 12301 to require the numbering of undocumented barges measuring more than 100 gross tons operating on the navigable waters of the United States.

This numbering system provides a means for identifying parties responsible for the now illegal abandonment of barges. More importantly, it will help identify those parties who may be held liable for the removal and proper disposal of any hazardous substances stored or deposited on board abandoned barges, as well as for the removal of the barges from the nation's waterways. This potential for liability would serve as a deterrent to barge abandonment.

Regulatory History

On October 18, 1994, the Coast Guard published a notice in the **Federal Register** [59 FR 52646] requesting comments on issues related to a numbering system for undocumented barges measuring more than 100 gross tons. The primary issues addressed in the notice concerned who should

administer a barge numbering system, what type of number should be required, and how much the numbering system would cost. The Coast Guard received twenty-one comments in response to the notice.

On July 6, 1998, the Coast Guard published an Advanced Notice of Proposed Rulemaking (ANPRM), discussing the proposed regulation, comments received from the previous notice, and a preliminary regulatory assessment (63 FR 36384). The comments we received are discussed below.

Discussion of Comments

We received comments from four respondents to our 1998 ANPRM (one respondent submitted the same comments twice; we are only counting it once). The comments directed our attention to such issues as the placement of the barge number markings, the source of the barge number, the application form, the phase-in period for the requirements based on the effective date of this rule, and fees for obtaining a barge number.

Placement of Markings

Three respondents stated that the Coast Guard should be consistent in marking requirements by following the regulations already in place for documented vessels. External markings would be an additional requirement on uninspected, undocumented barges and may interfere with other required markings, *e.g.* vessel name. The Coast Guard agrees that consistency is important and has written the requirements to mirror existing marking regulations as closely as possible. The purpose of these proposed markings and the circumstances under which they would be used are different, however. The proposed markings would be used to identify an owner of an abandoned barge. Many abandoned barges in the past contained unknown materials when abandoned, or were subsequently used as a dumping site for any number of unidentified materials. Many of these abandoned barges quickly become inaccessible to investigators without putting the investigator at great risk. Thus the quickest, safest, least expensive way to identify a barge owner is by requiring a unique number be located where it may be viewed without having to climb on the barge or enter any compartments or voids.

No respondents voiced objections to permanently marking the number on the vessel, although it was suggested that a particular method of marking be required. The Coast Guard values the diversity that exists and strives to permit as much autonomy as possible. As such, the Coast Guard would not be more specific than to require permanent markings as described in the proposed regulations, which are consistent with current requirements for marking documented vessels.

Barge Numbers

Three comments recommended recycling existing official numbers, and adding a prefix to those numbers to further identify the barge. The comments suggested using a ''D'' preceding the number to indicate a barge that had previously been documented, or using ''CG'' preceding the number to indicate a barge that is currently inspected but not documented. In both cases, the numbers would have already been recorded in Coast Guard records and official ''D'' numbers already permanently marked on barges. The Coast Guard agrees, and proposes that existing official numbers and CG numbers be accepted. However, we will not be distinguishing the numbers in the manner suggested by the commenter.

Application Form

One comment expressed concern that the information the Coast Guard proposed collecting was more than what was necessary to indicate ownership of a barge and would be broader than what is required for documented barges. We have developed a form titled Application for Certification of Number for Undocumented Barge that we feel limits the amount of information collected to what is absolutely necessary to enable the Coast Guard to identify and locate the owner of future abandoned barges. The application is available on the docket under the section labeled **ADDRESSES**. We welcome any comments on the application you have.

This comment also expressed concern for the increased burden on owners having to update the information each time an address, phone number, or the like changed. In addition, they argued that the new owner should inherit the responsibility for notifying the National Vessel Documentation Center (NVDC) of a change in ownership. We note that the ''old'' owner certainly retains an interest in ensuring that NVDC and the Coast Guard are aware of who owns and is responsible for a barge. The only times we propose requiring owners notify the NVDC of changes is after any change in ownership, or upon destruction of the barge. Previous owners would be required to notify NVDC of the change in ownership, whereas new owners would be required to submit a request for a certification of number issued to them within 60 days. Owners of barges that are destroyed would be required to notify NVDC of the destruction, just as owners of certificated barges must notify the Coast Guard when they elect to take a barge out of service within 60 days of destruction or removal from service.

One comment supported any opportunities to simplify the application process, including the use of electronic filing. The Coast Guard agrees, and will make electronic filing available in the future. The application will be available on the internet at the NVDC website. Applicants would be able to download the form and mail it in once they have completed filling it out.

Implementation Period

One comment suggested a phase-in period for the effective date of the regulation. Their suggestions included allowing up to six months to file an application and up to two years to mark barges. The Coast Guard agrees that the system proposed by these regulations could not be accomplished overnight and wishes to minimize the impact on owners' operations. Thus, the Coast Guard has proposed a one-year period for owners to submit applications to the Coast Guard, and a five-year period for the marking of all existing barges. Barges currently under construction would be numbered and marked in accordance with the regulations prior to being placed in service.

Fees

Three comments were opposed to fees. The argument followed that there is no benefit to owners from this regulation and no services rendered. The Coast Guard agrees and has not proposed a fee schedule to implement or maintain this requirement.

Miscellaneous

Comments varied on the costs associated with permanently marking barges, barge employment, maintenance intervals for undocumented barges, average life service, average annual construction rates, and average number of owners. A summary of the costs and benefits associated with this rulemaking is included below.

Discussion of Proposed Rules

General Requirements

The Coast Guard proposes adding regulations that would require owners of barges greater than 100 gross tons to obtain a unique number issued by the National Vessel Documentation Center (NVDC) for that barge. The barge

number would remain with it for the entirety of its life.

Regulations requiring the documentation and measurement of vessels are codified in 46 CFR parts 66 through 69. We propose establishing the requirements for numbering and marking barges over 100 gross tons in part 66, which is currently reserved. The requirements we propose to include in part 66 consist of a ''Definitions'' section that gives relevant meaning to specific terms used in this part, a section to identify those barges that must comply with this new barge numbering system, a method for applicable barges to calculate the barge's gross tonnage, and an application procedure for barge owners to follow when requesting a barge number from NVDC. The new regulations of part 66 would also identify to barges owners their right to appeal, the penalties for not fully complying with this part, and clarify what circumstances would invalidate a Certificate of Number.

In addition, barge owners would be required to permanently mark the barge by carving, punch-marking, or welding the number on some clearly visible internal structural part of the vessel, such as the main beam. The barge would also need to be permanently marked externally at the highest part of the vessel's hull or permanent structure, so that the number can be seen from either side.

Existing barges would be required to comply with the regulation no later than five years from the publication date of the final rule.

Previously documented barges would be allowed to use the official number or CG number previously assigned.

Definitions

The definitions for the terms necessary to determine gross tonnage, currently found in 46 CFR part 69, would be adopted. The proposed regulations would also add definitions for the terms ''barge'', ''barge number'', ''official number'', ''simplified measurement system'', ''undocumented barge'', and ''navigable waters''.

Regulatory Evaluation

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

A draft Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is available in the docket as indicated under **ADDRESSES**. A summary of the Evaluation follows:

The Abandoned Barge Act of 1992 (the Act) states ''The Secretary shall require an undocumented barge more than 100 gross tons operating on the navigable waters of the United States to be numbered.'' This analysis supports the regulatory evaluation of implementing a numbering system for undocumented barges of more than 100 gross tons, per the Act. The numbering system would provide an identification of the parties responsible and liable for the illegal abandonment of a barge. It would also enhance the Government's recovery of costs associated with the removal of the barge. Currently, there is no formal method for linking an abandoned undocumented barge to a responsible party, and consequently, there is little chance of the Government recovering costs incurred from the removal.

Population: There are approximately 20,000 undocumented barges greater than 100 gross tons operating in the navigable waters of the United States. Of these undocumented barges, it is estimated that 89 percent operate in the waters of the Mississippi River System and the Gulf Intracoastal Waterway. Additionally, most of the 20,000 undocumented barges are dry cargo barges (86 percent) with the remainder being construction barges (10 percent) and tank barges (4 percent).

Cost and benefit: Through analysis of this rulemaking we revealed that both the barge industry and the Government would incur the costs of implementing and administrating the barge number system. The cost to the barge industry includes administration costs, transportation costs and the cost to affix the number to the barge. The cost to the government includes cost associated with developing and implementing a database for the barge number system and the cost associated with administering the system. It is assumed that the Coast Guard would have sole responsibility for implementing and administrating the numbering system for abandoned barges.

Potential direct benefits would accrue to the Government. Most of these benefits would come from cost avoidance for removal and cleanup of abandoned barges. Additional benefits would be noticed from the reimbursement of Government incurred cost that is received from the responsible barge owner who abandoned his barge. There are no direct benefits identified for the barge industry.

Alternatives: Two alternative methods of numbering were posited: (1) Welding, punch-marking, or carving the number on the barge, and (2) painting the number on the barge. For welding the number to the barge, alternative 1, the assumption is that 15 percent of undocumented barges would need to tow the barge to an appropriate welding facility, whereas the other 85 percent of undocumented barges would not need a tow. For painting the number on the barge, alternative 2, the assumption is that the barge number would be painted without requiring a tow to a facility. Therefore, alternative 2 would not incur towing costs. With either alternative 1 or alternative 2, the estimated initial cost of $18,000 would be incurred by the Coast Guard to develop and install a database for managing information from the barge numbering system. The unit costs for the 30-year study period for both alternatives are summarized in Table 1.

TABLE 1.—UNIT COST SUMMARY

	Alternative 1 welding [1]	Alternative 2 painting
Government Costs:		
Administration Cost/Barge	$62	$62
Industry Cost/Barge:		
Existing Barges—Tow Req.	2,977	
Existing Barges—No Tow Req.	844	153
Future Barges	282	65
Total Cost/Barge:		
Existing Barges—Tow Req.	3,039	

TABLE 1.—UNIT COST SUMMARY—Continued

	Alternative 1 welding [1]	Alternative 2 painting
Existing Barges—No Tow Req.	906	215
Future Barges	344	127

[1] Costs include Gas-freeing, chemist certificate.

To develop the range of potential benefits that might result from alternative 1 and alternative 2, three scenarios are considered: (1) Barges greater than 100 tons are no longer abandoned (best case scenario), (2) illegally abandoned barges are abandoned with the number intact, and (3) illegally abandoned barges are abandoned with the barge number removed or obliterated (worst case scenario). The estimated annual benefits for each scenario are characterized in Table 2.

TABLE 2.—ANNUAL BENEFITS

	Scenario 1	Scenario 2	Scenario 3
Removal Cost Recovery	$250,000	$90,000	$0
Clean Up Cost Recovery	429,890	154,760	0
Investigation Savings	1,500	1,090	0
Total Annual Savings	681,390	245,850	0

The net present values (present value of benefits—present value of costs) were calculated over a 30-year period, from 2001 to 2030, using a discount rate of 7 percent. These values were discounted to year 1999. The total present value cost was calculated by multiplying the unit cost by the number of affected barges for each year from 2001 through 2030. The cost and benefit analyses in all three scenarios revealed no net benefit with welding the number to the barge (alternative 1). However, a cost and benefit analysis of the first scenario for alternative 2 identified a net benefit. The other two scenarios for painting the barge number on the barge revealed no net benefits. Table 3 summarizes the alternatives net present values for the 30-year period.

TABLE 3.—NET PRESENT VALUES—30 YEAR PERIOD

	Scenario 1	Scenario 2	Scenario 3
Alternative 1—Welding			
PV Benefit	$6,787,290	$2,448,903	$0
PV Cost	21,169,984	21,169,984	21,169,984
Net PV	(14,382,694)	(18,721,081)	(21,169,984)
Alternative 2—Painting			
PV Benefit	6,787,290	2,448,903	0
PV Cost	5,625,686	5,625,686	5,625,686
Net PV	1,161,604	(3,176,783)	(5,625,686)

The costs associated with welding the number to the barge were found to be significantly higher than the cost of painting. However, welding the numbers to the barges is the recommended alternative because it will be more difficult to remove the identification number on illegally abandoned barges. Therefore, it will help identify parties responsible for illegally abandoning barges and prevent future marine pollution from abandoned barges. Painted numbers can easily be removed, thus making it difficult to identify the responsible barge owner.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we considered whether this proposed rule would have a significant economic impact on a substantial number of small entities. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

Affected small entities: Companies that own and lease barges vary widely in size and operation. The Army Corp of Engineer's ''Waterborne Transportation Lines of the United States, Volume 2—Vessel Company Summary'' database was queried to identify owners of undocumented barges more than 100 gross tons. The query identified 660 owners with undocumented barge fleets ranging from 1 to 1,608 barges. The results of the query also revealed that 15 percent of the barge operators own over 85 percent of the affected barges. A majority (74 percent) of the affected owners have undocumented barge fleets of less than 10. Table 4 presents the number of affected owners by fleet size.

TABLE 4.—NUMBER OF AFFECTED FLEET OWNERS

Fleet size range	Number of owners	Percentage of owners	Number of affected barges	Percentage of affected barges (percent)
Greater than 1000	3	0.5%	4,040	23%
100 to 999	34	5.2%	8,970	50%
20 to 99	59	8.9%	2,594	14%
10 to 19	75	11.4%	1,024	6%
Fewer than 10	489	74.0%	1,329	7%
Total	660	100.0%	17,957	100%

The Small Business Administration, in 13 CFR 121–201, defines small business by either the number of employees or the amount of receipts in dollars. Revenue or labor-force information for many of the companies can be obtained from sources such as: Dun & Bradstreet, American Business and Lexis-Nexis. We assumed that if a company was a subsidiary or branch of a parent company, then that subsidiary or branch was inseparable from the larger firm.

From those 660 companies we drew a random sample of 101 companies using a confidence level of 95 percent and a confidence interval of 9. From the random sample of 101 companies we found data for 66 (or 65 percent) of them. Furthermore, from the 66 firms we identified 20 owned/operated by large companies and the remaining 46 owned/operated by small businesses. According to the small business size standard of the SIC (Standard Industrial Classification) and NAICS (North American Industry Classification System) Codes, we determined that the 46 identified entities qualified as small businesses because their revenues/number of employees do not exceed the specified standard in the corresponding SIC and NAICS codes definitions. This represents 69.7 percent of the 66 companies from which we have information. Therefore, we are 95 percent certain that 61.8 percent to 78.2 percent of the firms are small entities.

The determined small businesses cover several industry segments, therefore the corresponding SIC and NAICS codes analyzed for each company also cover a wide range. However, we determined that the most frequently identified SIC and NAICS codes when analyzing the small companies are as follows in table 5:

TABLE 5.—THE SMALL BUSINESSES MOST FREQUENTLY IDENTIFIED SIC AND NAICS CODES FROM THE RANDOM SAMPLE

Classification systems		Description		Definition		Number of small businesses
SIC	NAICS	SIC	NAICS	SIC	NAICS	
1629	23493	Heavy Construction, N.E.C.	Industrial Nonbuilding Structure Construction.	$27, 5Mil	$27, 5Mil	7
	23499		All Other Heavy Construction		$27, 5Mil	
3731	336611	Shipbuilding and Repair of Nuclear Propelled Ships.	Ship Building and Repair	1,000E	1,000E	3
4449	483211	Water Transportation of Freight, N.E.C.	Inland Water Transportation	500E	500E	8
4492	48833	Towing and Tug Boat	Navigational Services to Shipping	$5Mil	$5Mil	4
4499	532411	Water Transportation Services, N.E.C..	Commercial Air, Rail and Water Transportation Equipment Rental and Leasing.	$5Mil	$5Mil	3
5032	42132	Brick, Stone and Related Construction Materials.	Brick, Stone and Related Construction Material Wholesalers.	100E	100E	5

Cost for small entities: The costs to small business entities would depend only on the entity's fleet size. Below we show the impact on small businesses for welding barge numbers to the barge, our chosen alternative. We assume a 15 percent probability the vessel will need a tow, and an 85 percent probability that the vessel will not need a tow for welding. Therefore for the purpose of this analysis we estimate an expected cost of $1,164/barge (0.15 × $2,977/barge + 0.85 × $844/barge = $1,164/barge). The analyzed small business entities have relatively small fleets, with a median fleet size of 2. The median cost per company is $2,328/company (2 barges/company × $1,164/barge). The median revenue of a small business in our sample is $3,750,000. Therefore, the annual median impact on a small business is 0.06 percent ($2,328/$3,750,000 × 100) of annual revenue. For 45 of 46 small businesses the impact was less than 1 percent of the average revenues per year. For 46 of 46 small businesses the impact was less than 1.2 percent of the average revenue per year. In addition, the industry has a five year phase-in period to comply.

Therefore, the Coast Guard certifies under 5 U.S.C. 605(b) that this proposed rule would not have a significant economic impact on a substantial number of small entities. If you think that your business, organization, or governmental jurisdiction qualifies as a small entity and that this rule would have a significant economic impact on it, please submit a comment to the Docket Management Facility at the address under **ADDRESSES**. In your comment, explain why you think it qualifies and how and to what degree this rule would economically affect it.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), we want to assist small entities in

understanding this proposed rule so that they can better evaluate its effects on them and participate in the rulemaking. If the rule would affect your small business, organization, or governmental jurisdiction and you have questions concerning its provisions or options for compliance, please consult LCDR Robyn MacGregor, Project Manager, Office of Waterways Security and Safety (G–MWP), telephone 202–267–0483. Small businesses may send comments on the actions of Federal employees who enforce, or otherwise determine compliance with, Federal regulations to the Small Business and Agriculture Regulatory Enforcement Ombudsman and the Regional Small Business Regulatory Fairness Boards. The Ombudsman evaluates these actions annually and rates each agency's responsiveness to small business. If you wish to comment on actions by employees of the Coast Guard, call 1–888–REG–FAIR (1–888–734–3247).

Collection of Information

This proposed rule would call for a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520). As defined in 5 CFR 1320.3(c), ''collection of information'' comprises reporting, recordkeeping, monitoring, posting, labeling, and other, similar actions. The title and description of the information collections, a description of those who must collect the information, and an estimate of the total annual burden follow. The estimate covers the time for reviewing instructions, searching existing sources of data, gathering and maintaining the data needed, and completing and reviewing the collection.

Title: Numbering and Marking Undocumented Barges Greater than 100 gross tons.

Summary of the Collection of Information: The Abandoned Barge Act of 1992, sections 5301 to 5305 of Public Law 102–587, enacted on November 4, 1992, added a new chapter 47 to Title 46 of United States Code (46 U.S.C. 4701–4705) and amended 46 U.S.C. 12301 to require the numbering of undocumented barges measuring more than 100 gross tons operating on the navigable waters of the United States. The numbering system provides a means for identifying the parties responsible and liable for illegal abandonment. The information collections described in this supporting statement are necessary to implement the requirements described in 46 CFR part 66.

The table below identifies the subjects of the collection of information.

TABLE 6.—CFR, SUBJECT AND AFFECTED POPULATION

46 CFR part 66	Subject and affected population
Section 66.25(a)(1)	Filling out the Application for Certificate of Number for Undocumented Barge (CG–5683) and submitting it to the National Vessel Documentation Center. • The owners of undocumented barges greater than 100 gross tons.
Section 66.5 and 66.25(a)(2)	Recordkeeping the Certificate of Number for Undocumented Barge. • The owners of undocumented barges greater than 100 gross tons.
Section 66.25(a)(2)	Notifying the National Vessel Documentation Center of a replacement of a Certificate of Number for Undocumented Barge (CG–5683) document. • The owners of undocumented barges greater than 100 gross tons, in case of a defaced Certificate of Number.
Section 66.25(a)(3) and 66.35(d)	Notifying the National Vessel Documentation Center of the sale of a barge or upon the destruction of a barge with a valid Certificate of Number for Undocumented Barge (CG–5683). • The old owners of undocumented barges greater than 100 gross tons, in case barges are sold or destroyed.
Section 66.35(b)	Permanently attaching the number issued by the National Vessel Documentation Center to the barge. • The owners of undocumented barges greater than 100 gross tons.

Need for Information: This proposed rule contains burdens for the owners of undocumented barges greater than 100 gross tons. The information required is as follows:

(a) *Filling out the Application for Certificate of Number for Undocumented Barge (CG–5683) and submitting it to the National Vessel Documentation Center.* The owners of undocumented barges greater than 100 gross tons (including the owners of previously documented barges but no longer carrying a Certificate of Documentation) would fill out the Coast Guard Application for Certificate of Number for Undocumented Barge that contains the following necessary information to determine the ownership of the barge:

- The owner's name and address
- The barge length, breadth, depth, year built, hull material, barge name, and official number (if applicable).

(b) *Recordkeeping the Certificate of Number for Undocumented Barge (CG–5683).* Once the owners of barges obtain a Certificate of Number for Undocumented Barge, this would serve as evidence of ownership for determining liability in connection with the abandoned barge. Also, in case the owner applies for replacement of a defaced document, the outstanding Certificate of Number for Undocumented Barge must also be submitted to NVDC. This implies that the owner creating a recordkeeping burden must keep the Certificate of Number.

(c) *Notifying the National Vessel Documentation Center of a Replacement of a Certificate of Number for Undocumented Barge (CG–5683).* Owners requesting the replacement of a defaced document as a Certificate of Number for Undocumented Barge fill out the application form CG–5683 and submit the outstanding Certificate of Number for Undocumented Barge to NVDC.

(d) *Notifying the National Vessel Documentation Center of the sale of a barge or upon the destruction of a barge with a valid Certificate of Number for Undocumented Barge (CG–5683).* In case a barge is sold, the seller would have to provide a copy of the bill of sale to the NVDC. The owners would have to notify the NVDC by using Form CG–5683 upon the destruction of a barge with a valid Certificate of Number for Undocumented Barge within 60 days of the barge's destruction. This way the NVDC will maintain and update the numbering system for undocumented barges measuring more than 100 gross tons.

(e) *Permanently attaching the number issued by the National Vessel Documentation Center to the barge.* Owners (including the owners of

previously documented barges but no longer carrying a Certificate of Documentation) would have to permanently mark the barge by either welding, punch-marking, or carving the number issued by the NVDC, so that alteration, removal, or replacement would be obvious. The barge would be marked three times as follows: internally on the main beam and externally at the highest point on each side of the vessel's hull or permanent structure so that the number can be seen from either side.

Proposed Use of Information: This information collection would provide methods for identifying the parties responsible and liable for the illegal abandonment of a barge. It also would enhance the Government's recovery of costs associated with the removal of the barge. The information required for ''Numbering and Marking Undocumented Vessels greater than 100 gross tons'' would be collected on forms that are available at the National Vessel Documentation Center (NVDC). The information would have to be submitted by the vessel owner to NVDC. Once the application is processed, the NVDC would issue a Certificate of Number for Undocumented Barge to the owner who would then mark the issued barge number to the barge. Without the information an undocumented barge greater than 100 gross tons on the navigable waters of the United States would not be numbered as stated in the Abandonment Barge Act of 1992. Therefore, it would be impossible to identify the responsible owners of an illegally abandoned barge and consequently, there would be a little chance of the government recovering costs incurred from the removal.

Description of the Respondents: Each owner of undocumented Barge greater than 100 gross tons would be affected by these collections requirements.

Number of Respondents: We estimate those 660 owners of undocumented barges greater than 100 gross tons would be required to comply with the proposed requirements.

Frequency of Response Owners of undocumented barges greater than 100 gross tons would have to initially apply to the NVDC in order to obtain a Certificate of Number for Undocumented Barge. The number mentioned in the certificate would be permanently marked to the barge and would stay with the barge for the entirety of its life.

When needed, the owners of previously numbered barges can apply to the NVDC for the replacement of a defaced Certificate of Documentation. Also, in case of a change in ownership of a previously numbered barge, the new owner would have to submit an application for a Certificate of Number to be issued in the new owner's name. The seller would have to provide a copy of the bill of sale.

On occasion, upon destruction of a barge numbered under this part, an owner would have to notify NVDC using Form CG–568, Application for Certificate of Number.

Burden of Response: We identified 660 owners of 17,957 undocumented barges more than 100 gross tons identified, querying the Army Corp of Engineer's (USACE) ''Waterborne Transportation Lines of the United States, Volume 2—Vessel Company Summary'' database. The total estimated number of undocumented barges is approximately 20,000 and includes construction barges. The number was estimated based on queries of USACE data and the Coast Guard Marine Safety Management System data of all currently undocumented barges.

The 1,400 previously documented barges no longer carrying a Certificate of Documentation are included in the 20,000 total number of undocumented barges. In order to estimate the number of affected barges in future years (i.e., barges to be constructed in the future that will require numbering), we used a regression analysis. We based our analysis on the Coast Guard's Marine Safety Information System data series concerning the number of barges over 100 gross tons constructed in the period of time from 1985 up to 1999. We forecasted the number of new constructed undocumented barges over 100 gross tons to be constructed for the regulatory evaluation period of time.

In the first five years, from 2001 up to 2005, owners of currently undocumented barges (20,000) would have to comply with the proposed regulation as well as owners of the barges that are sold or destroyed and owners of newly constructed barges. Thereafter, beginning with 2006 the annual burden will be placed only on owners of newly constructed barges and owners of sold or destroyed barges. The burden due to the currently 20,000 undocumented barges is evenly distributed in the five-year phase in period. Therefore, we estimate that owners of 4,000 barges/year would have to apply for a Certificate of Undocumented Barge.

We are presenting for public comment our estimate of affected entities and the burden posed to them for the first three years this proposed rule would be enforced. These estimates are found in table 7.

TABLE 7.—NUMBER OF AFFECTED BARGES

Year	Currently undocumented barges	New constructed barges (forecasted)	Sold barges per year (10% (2+3))	Total permanently marked barges (2+3)	Total barges for which NVDC will be notified (2+3+4)
1	2	3	4	5	6
2001	4,000	513	451	4,513	4,964
2002	4,000	525	453	4,525	4,978
2003	4,000	536	454	4,536	4,990
Average per year	4,000	525	453	4,525	4,978

We indicate below the hour burden according to the requirements in this Collection of Information.

(a) *Filling out the Application for Certificate of Number for Undocumented Barge (CG–5683) and submitting it to the National Vessel Documentation Center. We estimate that the average time for filling out this form is 15 minutes. The owners of 4,978 barges would have to fill out the form.*

Annual burden: 0.25 hours/barge × 4,978 barges/year = 1,245 hours/year.

(b) *Recordkeeping the Certificate of Number for Undocumented Barge (CG–*

5683). We estimate that it takes an owner 10 minutes to file the Certificate of Number for Undocumented Barges in an accessible place.

Annual burden: 0.17 hours/barge × 4,978 barges/year = 846 hours/year.

(c) *Notifying the National Vessel Documentation Center of a replacement of a Certificate of Number for Undocumented Barge (CG–5683) document.* We estimate that the number of replacements of defaced Certificate of Number documents is less than 5 percent (249 barges = 5% × 4,978 barges per year) from the total number of barges for which the owners would have a Certificate of Number. We estimate that it would take 15 minutes to an owner to fill out the application for the Certificate of Number and 5 minutes to submit the defaced Certificate of Number to the NVDC.

Annual burden: 0.33 hours/barge × 249 barges/year = 82 hours/year.

(d) *Notifying the National Vessel Documentation Center of a change in ownership of the barge, or upon the destruction of a barge with a valid Certificate of Number for Undocumented Barge (CG–5683).* We estimate that it would take 10 minutes to an owner to submit a copy of the bill of sale or the Certificate of Number for Undocumented Barges to the NVDC as follows:

- If the barge ownership changes : we estimate that 10 percent of 4,978 undocumented barges would be sold per year (498 barges).
- Upon the destruction of a barge: 10 percent of 4,978 barges per year (498 barges).

Annual burden: 0.17 hours/year × 996 barges = 169 hours/year.

(e) *Permanently attaching the number issued by the National Vessel Documentation Center to the barge.* Owners (including the owners of previously documented barges but no longer carrying a Certificate of Documentation) would have to permanently mark the barge by carving, punch-marking, or welding the number issued by the National Vessel Documentation Center. The barge would be marked three times as follows: internally on the main beam and also externally at the highest part of the vessel's hull or permanent structure so that the number can be seen from either side. We estimate that it takes 2 hours to permanently affix the numbers to a barge.

Annual burden: 2 hours/year × 4,525 barges = 9,050 hours/year.

The total annual hour burden is: 1,245hours/year + 846hours/year + 82hours/year + 169hours/year + 9,050hours/year = 11,392hours/year.

Annualized Costs: The owners of undocumented barges would incur costs. We estimated the annual average burden for information collection activities would cost $724,737 annually in current dollars. We identify below the cost burden according to the requirements covered in this Collection of Information.

(a) *Filling out the Application for Certificate of Number for Undocumented Barge (CG–5683) and submitting it to the National Vessel Documentation Center.* Approximately 1,245 burden hours would be required annually for filling out applications for Certificate of Numbers for Undocumented Barges to NVDC, by vessel owners. We estimate wages for a barge owner at $66 per hour.

The annual cost to the industry is: $82,170 (1,245hours/year × $66/hour).

(b) *Recordkeeping the Certificate of Number for Undocumented Barge (CG–5683).* Approximately 846 burden hours per year would be required by industry to file the certificate of number in a safe, accessible place. We estimate wages for a barge owner at $66 per hour.

The annual cost to the industry is: $55,836 (846hours/year × $66/hour).

(c) *Notifying the National Vessel Documentation Center of a replacement of a Certificate of Number for Undocumented Barge (CG–5683) document.* Approximately 82 burden hours per year would be required by industry to apply for replacement of a defaced document, the outstanding Certificate of Number. The Coast Guard estimates wages for a barge owner at $66 per hour.

The annual cost to the industry is: $5,412 (82hours/year × $66/hour).

(d) *Notifying the National Vessel Documentation Center of a change in ownership of the barge or upon the destruction of a barge with a valid Certificate of Number for Undocumented Barge (CG–5683).* Approximately 169 burden hours would be required annually for surrendering bills of sale or Certificates of Number for Undocumented Barge to NVDC, by vessel owners when there is a change in ownership of a barge, or upon the destruction of barges. We estimate wages for a barge owner at $66 per hour.

The annual cost to the industry is: $11,169 (169hours/year × $66/hour).

(e) *Permanently attaching the number issued by the National Vessel Documentation Center to the barge.* Approximately 9,950 burden hours would be required annually to permanently attach (weld) the numbers to barges. We estimate the hourly rate of a welder to be $63 per hour.

The annual cost to the industry is: $570,150 (9,050hours/year × $63/hour).

The total annual cost burden to the industry is: $82,170/year + $55,83/year + $5,412/year + $11,169/year + $570,150/year = $724,737/year.

Estimate of Total Annual Burden: We estimated the annual average burden for information collection activities would be 11,392 hours annually.

Public Comments on the Collection of Information: As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), we have submitted a copy of this proposed rule to the Office of Management and Budget (OMB) for its review of the collection of information.

We ask for public comment on the proposed collection of information to help us determine how useful the information is; whether it can help us perform our functions better; whether it is readily available elsewhere; how accurate our estimate of the burden of collection is; how valid our methods for determining burden are; how we can improve the quality, usefulness, and clarity of the information; and how we can minimize the burden of collection.

If you submit comments on the collection of information, submit them both to OMB and to the Docket Management Facility where indicated under **ADDRESSES**, by the date under **DATES**.

You need not respond to a collection of information unless it displays a currently valid control number from OMB. Before the requirements for this collection of information become effective, we will publish notice in the **Federal Register** of OMB's decision to approve, modify, or disapprove the collection.

Federalism

Under Executive Order 13132, section 3 (b), the Coast Guard finds that a uniform system of identifying the owners of undocumented barges is in the national interest because of the problem of abandoned barges identified by Congress in the Abandoned Barge Act, 46 U.S.C. 4701–4705. One of the ways Congress specified for determining whether a barge is abandoned is if the owner states that it is not abandoned, 46 U.S.C. 4702(a)(3). However, that presupposes that the Coast Guard can identify who the current owner is. The Coast Guard already maintains a listing for documented barges. That leaves the Coast Guard unable to identify the owners of undocumented barges.

On October 18, 1994, the Coast Guard published a Request for Comments on this rulemaking project. (59 FR 52646) We noted our intent to consult with

State Boating Law Administrators, State Numbering Authorities, and with the National Association of State Boating Law Administrators' (NASBLA). We also solicited general comments, and asked a number of direct questions. One of those questions was whether the Coast Guard, the individual states, or some other entity should have the authority to assign numbers and maintain ownership information for undocumented barges. We received 21 comments, seventeen of which answered this question. All seventeen responded that the Coast Guard should be the entity assigning numbers and maintaining ownership information. Seven of these respondents were state agencies. (The Request for Comments and all received comments are available for viewing in the electronic docket.)

On July 6, 1998, we published an ANPRM which indicated our intent to establish the numbering system outlined in this NPRM. No commenters, state or otherwise, requested that the system be run by a State or other entity. (The ANPRM and comments are available for viewing in the electronic docket.)

Given this established lack of State interest in regulating in this area, any further consultation with State and local officials under Executive Order 13132, Section 3 (b) is unnecessary and not required by that order.

Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531–1538) requires Federal agencies to assess the effects of their regulatory actions not specifically required by law. In particular, the Act addresses actions that may result in the expenditure by a State, local, or tribal government, in the aggregate, or by the private sector of $100,000,000 or more in any one year. Though this proposed rule would not result in such an expenditure, we do discuss the effects of this rule elsewhere in this preamble.

Taking of Private Property

This proposed rule would not effect a taking of private property or otherwise have taking implications under E.O. 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Civil Justice Reform

This proposed rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Protection of Children

We have analyzed this proposed rule under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or risk to safety that may disproportionately affect children.

Environment

We considered the environmental impact of this proposed rule and concluded that, under figure 2–1, paragraph (34)(d), of Commandant Instruction M16475.1C, this proposed rule is categorically excluded from further environmental documentation. The proposed rule is a procedural regulation that does not have any environmental impact because the action does not have a significant effect on the quality of the human environment. A ''Categorical Exclusion Determination'' is available in the docket where indicated under **ADDRESSES**.

List of Subjects in 46 CFR Part 66

Penalties, Reporting and recordkeeping requirements, Vessels.

For the reasons discussed in the preamble, the Coast Guard proposes to add 46 CFR part 66 to read as follows:

PART 66—REQUIREMENT FOR UNDOCUMENTED BARGES

Sec.
66.5 Purpose.
66.10 Applicability.
66.15 Definitions.
66.20 Determining the gross tonnage for a barge.
66.25 Application procedure.
66.30 Invalidation of Certificate of Number.
66.35 Marking requirements.
66.40 Right of appeal.
66.45 Penalties.

Authority: 46 U.S.C. 4701 *et seq.*, 12301; 49 CFR 1.46(zz).

§ 66.5 Purpose.

A Certificate of Number for Undocumented Barge is required for the operation of undocumented barges greater than 100 gross tons on the navigable waters of the United States and serves as evidence of ownership for determining liability in connection with abandoned barges.

§ 66.10 Applicability.

This part applies to your barge if it meets the following three conditions:

(a) It is greater than 100 gross tons;

(b) It operates on the navigable waters of the United States; and

(c) It is not currently documented by the U.S. Coast Guard.

§ 66.15 Definitions.

The following definitions are for terms used in this part.

Barge means any vessel not equipped with a means of self-propulsion.

Barge number means that unique number issued to a barge by the National Vessel Documentation Center (NVDC). The barge number will remain with the barge throughout its life.

Navigable waters means the waters of the United States, including the territorial seas.

Official number means the number assigned and marked on a currently or previously documented barge in accordance with 46 CFR part 67, subparts H and I.

Simplified measurement system has the same meaning as is given in 46 CFR part 69, subpart E.

Undocumented barge means a barge that does not have a current Certificate of Documentation issued under 46 CFR part 67.

§ 66.20 Determining the gross tonnage for a barge.

(a) If your barge must comply with this part, you may determine its gross tonnage by using the simplified measurement system described in 46 CFR 69.209. The terms and measurements used in that section have the meanings assigned to them in 46 CFR 69.203 and 69.207, respectively. You do not need to submit the application for measurement services outlined in 46 CFR 69.205, and no tonnage certifying document will be issued.

(b) If you do not use the Simplified Measurement System, the gross tonnage is the tonnage assigned under any other applicable measurement system of 46 CFR part 69, as indicated on an appropriate tonnage certifying document. In this case, the gross tonnage assigned under the Standard or Dual Measurement systems (46 CFR part 69, subparts C and D, respectively) should be used if your vessel is also assigned tonnage under the Convention system (46 CFR part 69, subpart B).

§ 66.25 Application procedure.

(a) As owner of a vessel applying for a Certificate of Number for Undocumented Barge (CG–5683); requesting replacement of a Certificate of Number for Undocumented Barge (CG–5683); or providing notification of the sale of a barge with a valid Certificate of Number for Undocumented Barge (CG–5683) you must submit the following to the National Vessel Documentation Center (NVDC):

(1) Application for Certificate of Number for Undocumented Barge (CG–5683);

(2) If the application is for replacement of a defaced document, the outstanding Certificate of Number for Undocumented Barge (CG–5683); or

(3) If providing notification of a transfer of ownership, the seller must provide a copy of the bill of sale.

(b) New owners of barges previously numbered under this part must submit an application for a Certificate of Number to be issued in the new owner's name.

(c) Upon receipt of the Certificate of Number for Undocumented Barge (CG–5683), ensure that the vessel is marked in accordance with the requirements set forth in § 66.9 of this part.

(d) Upon destruction of a barge numbered under this part, an owner must notify NVDC using Form CG–5683, Application for Certificate of Number. This notification must be made within 60 days of the barge's destruction.

(e) Applications for Certificate of Number of Undocumented Barge may be obtained from the National Vessel Documentation Center or downloaded from their website.

§ 66.30 Invalidation of Certificate of Number.

A Certificate of Number becomes invalid upon the transfer of ownership of a barge numbered under this part.

§ 66.35 Marking requirements.

(a) Your barge number must be marked in block type Arabic numerals not less than four (4) inches in height on:

(1) Some clearly visible internal structural part of the vessel; and

(2) At the highest part of the vessel's hull or permanent structure such that the number can be seen from either side.

(b) Your barge number must be permanently attached to the vessel, by either welding, punch-marking, or carving, so that alteration, removal, or replacement would be obvious.

(c) If this part applies to you, and your undocumented barge is in operation on the date this rule is published, you have five years from that date to obtain a barge number and meet the permanent marking requirements of this part.

(d) If your undocumented barge has a build date after publication of this rule, you must obtain a Certificate of Number and meet the permanent marking requirements of this part prior to placing the barge in operation.

§ 66.40 Right of appeal.

If you are directly affected by this part and wish to appeal a decision or action made by or on behalf of the U.S. Coast Guard, you may do so in accordance with 46 CFR part 1, subpart 1.03.

§ 66.45 Penalties.

Violation of this part is subject to the criminal and civil penalties set forth in 46 U.S.C. 12309. If the violation involves the operation of a vessel, the vessel also is liable in rem to the United States Government for a civil penalty of not more than $1,000.

Dated: January 5, 2001.

R.C. North,

Rear Admiral, Coast Guard, Assistant Commandant for Marine Safety and Environmental Protection.

[FR Doc. 01–870 Filed 1–10–01; 8:45 am]

BILLING CODE 4910–15–U

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 01–4, MM Docket No. 01–3, RM–10010]

Digital Television Broadcast Service; Jacksonville, NC

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission requests comments on a petition filed by The University of North Carolina, licensee of noncommercial educational station WUNM–TV, Jacksonville, North Carolina, requesting the substitution of DTV channel *18 for station WUNM–TV's assigned DTV channel *44. DTV Channel *18 can be allotted to Jacksonville, North Carolina, in compliance with the principle community coverage requirements of Section 73.625(a) at reference coordinates (35–06–18 N. and 77–20–15 W.). As requested, we propose to allot DTV Channel *18 to Jacksonville with a power of 65 and a height above average terrain (HAAT) of 561 meters.

DATES: Comments must be filed on or before February 26, 2001, and reply comments on or before March 13, 2001.

ADDRESSES: Federal Communications Commission, 445 12th Street, SW., Room TW–A325, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: Malcolm G. Stevenson, Schwartz, Woods & Miller, 1350 Connecticut Avenue, NW., Suite 300, Washington, DC 20036–1717.

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Mass Media Bureau, (202) 418–1600.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rule Making, MM Docket No. 01–3, adopted January 3, 2001, and released January 5, 2001. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center 445 12th Street, SW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Services, Inc., (202) 857–3800, 1231 20th Street, NW., Washington, DC 20036.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, see 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Television, Digital television broadcasting.

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR part 73 as follows:

PART 73—TELEVISION BROADCAST SERVICES

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, and 336.

§ 73.622 [Amended]

2. Section 73.622(b), the Table of Digital Television Allotments under North Carolina is amended by removing DTV Channel *44 and adding DTV Channel *18 at Jacksonville.

Federal Communications Commission.

Barbara A. Kreisman,

Chief, Video Services Division, Mass Media Bureau.

[FR Doc. 01–678 Filed 1–10–01; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 01–01, MM Docket No. 01–1, RM–10013]

Digital Television Broadcast Service; Macon, GA

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission requests comments on a petition filed by Gannett Georgia, L.P., licensee of station WMAZ–TV, NTSC channel 13, Macon, Georgia, requesting the substitution of DTV channel 4 for station WMAZ–TV's assigned DTV channel 45. DTV Channel 4 can be allotted to Macon, Georgia, in compliance with the principal community coverage requirements of Section 73.625(a) at reference coordinates (32–45–10 N. and 83–33–32 W.). As requested, we propose to allot DTV Channel 4 to Macon with a power of 5.0 and a height above average terrain (HAAT) of 238 meters.

DATES: Comments must be filed on or before February 26, 2001, and reply comments on or before March 13, 2001.

ADDRESSES: Federal Communications Commission, 445 12th Street, SW., Room TW–A325, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: Marnie K. Sarver, Wiley, Rein & Fielding, 1776 K Street, NW., Washington, DC 20006 (Counsel for Gannett Georgia, L.P.).

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Mass Media Bureau, (202) 418–1600.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rule Making, MM Docket No. 01–1, adopted January 2, 2001, 2000, and released January 5, 2000. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street, SW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Services, Inc., (202) 857–3800, 1231 20th Street, NW., Washington, DC 20036.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, see 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Television, Digital television broadcasting.

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR part 73 as follows:

PART 73—TELEVISION BROADCAST SERVICES

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, and 336.

§ 73.622 [Amended]

2. Section 73.622(b), the Table of Digital Television Allotments under Georgia is amended by removing DTV Channel 45 and adding DTV Channel 4 at Macon.

Federal Communications Commission.

Barbara A. Kreisman,

Chief, Video Services Division, Mass Media Bureau.

[FR Doc. 01–679 Filed 1–10–01; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 01–18, MM Docket No. 01–2, RM–10036]

Television Broadcast Service; New Iberia, LA

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: The Commission requests comments on a petition filed by Iberia Communications, L.L.C., an applicant for vacant NTSC TV channel 36 at New Iberia, Louisiana, requesting the substitution of channel 53 for channel 36 at New Iberia. Channel 53 can be allotted to New Iberia consistent with Sections 73.623(c) of the Commission's Rules with a minus offset at coordinates (30–12–48 N. and 91–45–58 W.). We will not accept competing expressions of interest in the use of television channel 53– at New Iberia pursuant to the Commission's guidelines stated in Public Notice released on November 22, 1999, DA 99–2505.

DATES: Comments must be filed on or before March 2, 2001, and reply comments on or before March 19, 2001.

ADDRESSES: Federal Communications Commission, 445 12th Street, SW., Room TW–A325, Washington, DC 20554. In addition to filing comments with the FCC, interested parties should serve the petitioner, or its counsel or consultant, as follows: Howard M. Weiss, Anne Goodwin Crump, Fletcher, Heald & Hildreth, PLC, 1300 North 17th Street, Eleventh Floor, Arlington, Virginia 22209 (Counsel for Iberia Communications, LLC).

FOR FURTHER INFORMATION CONTACT: Pam Blumenthal, Mass Media Bureau, (202) 418–1600.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rule Making, MM Docket No. 01–2, adopted January 8, 2001, and released January 9, 2001. The full text of this Commission decision is available for inspection and copying during normal business hours in the FCC Reference Center 445 12th Street, SW., Washington, DC. The complete text of this decision may also be purchased from the Commission's copy contractor, International Transcription Services, Inc., (202) 857–3800, 1231 20th Street, NW., Washington, DC 20036.

Provisions of the Regulatory Flexibility Act of 1980 do not apply to this proceeding.

Members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel allotments. See 47 CFR 1.1204(b) for rules governing permissible *ex parte* contacts.

For information regarding proper filing procedures for comments, see 47 CFR 1.415 and 1.420.

List of Subjects in 47 CFR Part 73

Television broadcasting.

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR part 73 as follows:

PART 73—TELEVISION BROADCAST SERVICES

1. The authority citation for part 73 continues to read as follows:

Authority: 47 U.S.C. 154, 303, 334, and 336.

§ 73.606 [Amended]

2. Section 73.602(b), the Table of Television Allotments under Louisiana is amended by removing TV Channel 36– and adding TV Channel 53– at New Iberia.

Federal Communications Commission.

Barbara A. Kreisman,

Chief, Video Services Division, Mass Media Bureau.

[FR Doc. 01–900 Filed 1–10–01; 8:45 am]

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Notices

Federal Register
Vol. 66, No. 8
Thursday, January 11, 2001

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

Rural Utilities Service

Associated Electric Cooperative, Inc., Notice of Availability of an Environmental Assessment

AGENCY: Rural Utilities Service, USDA.

ACTION: Notice of availability of an environmental assessment.

SUMMARY: Notice is hereby given that the Rural Utilities Service (RUS) is issuing an environmental assessment with respect to the potential environmental impacts related to the construction of three 100-megawatt, natural gas fired combustion turbine electric generators in west-central Johnson County, Missouri. RUS may provide financing assistance to Associated Electric Cooperative for the project.

FOR FUTHER INFORMATION CONTACT: Bob Quigel, Environmental Protection Specialist, Engineering and Environmental Staff, Rural Utilities Service, Stop 1571, 1400 Independence Avenue, SW., Washington, DC 20250–1571, telephone: (202) 720–0468. Bob's e-mail address is *bquigel@rus.usda.gov.* Information is also available from Jerry Bindel of Associated Electric Cooperative, P.O. Box 754, Springfield, Missouri 65801–0754 telephone (417) 885–9272. Jerry's e-mail address is *jbindel@aeci.org.*

SUPPLEMENTARY INFORMATION: Associated Electric Cooperative proposes to construct and operate three, 100-megawatt, simple cycle combustion turbine generators on an 80 acre site in Johnson County, Missouri. The entire plant would use about 11 acres of the site. The site is located approximately 2 miles north of Holden, Missouri. State Highway 131 borders the eastern edge of the site.

The primary fuel for the units would be natural gas with fuel oil backup. The generators are Siemens Westinghouse V84.2 dry low-nitrogen combustors. Each generating unit would be approximately 60 feet wide and 150 feet long. The exhaust stacks would be 90 feet high. An electric substation, a 100-foot by 60-foot maintenance building, water storage tanks, fuel oil storage tank and unloading area, a gas conditioning area and pump house would be located near the combustion turbines. A 150-foot microwave tower would be located on site to enable controlling the plant from a remote location. A 1,300-foot natural gas pipeline and approximately 2.6 miles of electric transmission line will be needed at the site to supply natural gas to the units and connect them to the existing electric transmission grid.

Subsequent to receiving a stormwater permit from the Missouri Department of Natural Resources (MDNR), Associated Electric Cooperative initiated land clearing activities at the site. However, no permanent foundations or plant structures can be constructed on the site until Associated Electric Cooperative has received the air permit for the project from the Air Quality Control Program of the MDNR.

Associated Electric Cooperative prepared an environmental analysis for RUS which describes the project and assesses its environmental impacts. RUS has conducted an independent evaluation of the environmental analysis and believes that it accurately assesses the impacts of the proposed project. This environmental analysis will serve as RUS' environmental assessment of the project. No significant impacts are expected as a result of the construction of the project.

The environmental assessment can be reviewed at the Associated Electric Cooperative headquarters located at 2814 South Golden Street, Springfield, Missouri 65807–3213. Copies of this document will also be available at the Holden Public Library, 101 West Third Street, Holden, Missouri 64040–1302, telephone (816) 732–4545. It can also be reviewed at the headquarters of RUS at the address provided above.

Questions and comments should be sent to RUS at the address provided. RUS will accept questions and comments on the environmental assessment for at least 30 days from the date of publication of this notice.

Any final action by RUS related to the proposed project will be subject to, and contingent upon, compliance with all relevant Federal environmental laws and regulations and completion of environmental review procedures as prescribed by the 7 CFR part 1794, Environmental Policies and Procedures.

Dated: January 4, 2001.

Lawrence R. Wolfe,

Acting Director, Engineering and Environmental Staff.

[FR Doc. 01–783 Filed 1–11–01; 8:45 am]

BILLING CODE 3410–15–P

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

[Docket No.: 000911256–0256–01]

RIN 0693–ZA40

Small Grant Programs

Availability of 2001 Funds for: (1) Precision Measurement Grants—Availability of Funds; (2) Physics Laboratory (PL), 2001 Summer Undergraduate Research Fellowships (SURF); (3) Materials Science and Engineering Laboratory (MSEL), 2001 Summer Undergraduate Research Fellowships (SURF); (4) Manufacturing Engineering Laboratory (MEL), 2001 Summer Undergraduate Research Fellowships (SURF); (5) Information Technology Laboratory (ITL), 2001 Summer Undergraduate Research Fellowships (SURF); (6) Building and Fire Research Laboratory (BFRL), 2001 Summer Undergraduate Research Fellowships (SURF); (7) Electronics and Electrical Engineering Laboratory (EEEL), 2001 Summer Undergraduate Research Fellowships (SURF); (8) Materials Science and Engineering Laboratory (MSEL) Grants Program—Availability of Funds; (9) Fire Research Grants Program—Availability of Funds; (10) Physics Laboratory (PL) Grants Program—Availability of Funds; (11) Chemical Science and Technology Laboratory (CSTL) Grants Program—Availability of Funds; (12) Manufacturing Engineering Laboratory (MEL) Grants Program—Availability of Funds; and; (13) Electronics and Electrical Engineering Laboratory (EEEL) Grants Program—Availability of Funds.

AGENCY: National Institute of Standards and Technology, Commerce.

ACTION: Notice

SUMMARY: The purpose of this notice is to inform potential applicants that the following programs of the National Institute of Standards and Technology (NIST) are offering financial assistance as follows: (1) The Precision Measurement Grants Program; (2) the 2001 Summer Undergraduate Research Fellowships (SURF) in the areas of Atomic, Molecular and Optical (AMO) and Radiation Physics, in Materials Science and Engineering, in Manufacturing Engineering, in Information Technology, in Building and Fire Research, and in Electronics and Electrical Engineering; (3) the Materials Science and Engineering Grants Program; (4) the Fire Research Grants Program; (5) the Physics Laboratory Grants Program; (6) the Chemical Science and Technology Laboratory Grants Program; (7) the Manufacturing Engineering Laboratory (MEL) Grants Program, and (8) the Electronics and Electrical Engineering (EEEL) Grants Program. In order to make any awards this fiscal year, it is necessary to begin the application process now. The issuance of awards is subject to the availability of FY 2001 funds. Further notice will be made in the **Federal Register** about the final status of funding for these programs at the appropriate time. NIST shall not be liable for any proposal preparation costs.

The Precision Measurement Grants Program is seeking proposals for significant, primarily experimental, research in the field of fundamental measurement or the determination of fundamental constants.

The programs ''SURFing the Physics Laboratory,'' ''SURFing the Materials Science and Engineering Laboratory,'' ''SURFing the Manufacturing Engineering Laboratory,'' ''SURFing the Information Technology Laboratory,'' ''SURFing the Building and Fire Research Laboratory,'' and ''SURFing the Electronics and Electrical Engineering Laboratory'' will provide an opportunity for the NIST Physics Laboratory (PL), Materials Science and Engineering Laboratory (MSEL), Manufacturing Engineering Laboratory (MEL), Information Technology Laboratory (ITL), Building and Fire Research Laboratory (BFRL), and Electronics and Electrical Engineering Laboratory (EEEL), and the National Science Foundation (NSF) to join in a partnership to encourage outstanding undergraduate students to pursue careers in science and engineering.

The PL program will involve students in world-class atomic, molecular, optical (AMO) and radiation physics research with internationally known physicists in the NIST Physics Laboratory. The MSEL program will provide research opportunities with internationally known NIST scientists in the fields of ceramics, solid state chemistry, metallurgy, polymers, neutron condensed matter science, and materials reliability. The MEL program will provide research opportunities with internationally known NIST scientists in the fields of intelligent systems, manufacturing metrology, precision engineering, and manufacturing systems integration. The ITL program will provide research opportunities with internationally known NIST scientists in the field of networking, software quality, security, information access, convergent systems, mathematical science, and statistics. The BFRL program will provide research opportunities with internationally known NIST scientists in the fields of building materials (concrete, coating), structure (earthquake), building environment (indoor air quality, thermal machinery), and fire science and engineering. The EEEL program will provide research opportunities with internationally known NIST scientists in the fields of semiconductors (including mainstream silicon, power devices, and compound semiconductors), fundamental electrical measurements, electronic instrumentation, electrical systems, and electronic information. The NIST Program Directors will work with physics, materials science, manufacturing engineering, intelligent systems, automated production, precision engineering, information technology, building materials, constructed structures, and other science-related department chairs and directors of multi-disciplinary academic organizations to identify outstanding undergraduates (including graduating seniors) who would benefit from off-campus summer research in an honors academy environment.

The Materials Science and Engineering Laboratory (MSEL) Grants Program is continuing its program for grants and cooperative agreements in the following fields of research: Ceramics, Metallurgy, Polymer Sciences, Neutron Scattering Research and Spectroscopy.

The Fire Research Grants Program is limited to innovative ideas in the fire research area generated by the proposal writer, who chooses the topic and approach, consistent with the program description and objectives of this notice.

The Physics Laboratory (PL) Grants Program will provide grants and cooperative agreements in the following fields of research: Electron and Optical Physics, Atomic Physics, Optical Technology, Ionizing Radiation, and Time and Frequency.

The Chemical Science and Technology Laboratory (CSTL) Grants Program will provide grants and cooperative agreements in the following fields of research: Biotechnology, Process Measurements, Surface and Microanalysis Science, Physical and Chemical Properties, and Analytical Chemistry.

The Manufacturing Engineering Laboratory (MEL) Grants Program is initiating a program for grants and cooperative agreements in the following fields of research: Dimensional Metrology for Manufacturing, Mechanical Metrology for Manufacturing, Intelligent Systems, and Information Systems Integration for Application in Manufacturing.

The Electronics and Electrical Engineering (EEEL) Grants Program provides grants and cooperative agreements for the development of fundamental electrical metrology and of metrology supporting industry and government agencies in the broad areas of semiconductors, electronic instrumentation, radio-frequency technology, optoelectronics, magnetics, video, electronic commerce as applied to electronic products and devices, the transmission and distribution of electrical power, national electrical standards (fundamental, generally quantum-based physical standards), and law enforcement standards.

Precision Measurement Grants Program

Dates: Applicants for the Precision measurement Grants Program must submit an abbreviated proposal for preliminary screening. Based on the merit of the abbreviated proposal, applicants will be advised whether a full proposal should be submitted. The abbreviated proposals must be received at the address listed below no later than the close of business February 1, 2001. The semi-finalists will be notified of their status by March 23, 2001, and will be requested to submit full proposals to NIST by close of business on May 11, 2001. NIST expects to issue awards on or before September 30, 2001.

Addresses: For the Precision Measurement Grants Program, applicants are requested to direct technical questions and submit an abbreviated proposal (original and two (2) signed copies), with a description of their proposed work of no more than five (5) double spaced pages to: Dr. Peter J. Mohr, Chairman, NIST Precision Measurement Grants Committee,

National Institute of Standards and Technology, Bldg. 225, Rm. B161, 100 Bureau Drive, Stop 8401, Gaithersburg, MD 20899–8401, Tel: (301) 975–3217, E-mail: mohr@nist.gov, Website: http://physics.nist.gov/pmg.

Authority: The authority for the Precision Measurement Grants Program is as follows: As authorized by 15 U.S.C. 272(b) and 9c), NIST conducts directly, and supports through grants and cooperative agreements, a basic and applied research program in the general area of fundamental measurement and the determination of fundamental constants of nature.

Program Description and Objectives: The program description and objectives for the Precision Measurement Grants Program are as follows: As part of its research program, since 1970 NIST has awarded Precision Measurement Grants to U.S. universities and colleges so that faculty may conduct significant, primarily experimental research in the field of fundamental measurement or the determination of fundamental constants. NIST sponsors these grants and cooperative agreements primarily to encourage basic, measurement-related research in U.S. universities and colleges and to foster contacts between NIST scientists and those faculty members of U.S. academic institutions who are actively engaged in such work. The Precision Measurement Grants are also intended to make it possible for researchers to pursue new, fundamental measurement ideas for which other sources of support may be difficult to find. There is some latitude in research topics that will be considered under the Precision Measurement Grants Program. The key requirement is that the proposed project support NIST's ongoing work in the field of basic measurement science, which includes:

1. Experimental and theoretical studies of fundamental physical phenomena which test the basic laws of physics or which may lead to new or improved fundamental measurement methods and standards.

2. The determination of important fundamental physical constants.

Although proposals for either experimental or theoretical research will be considered, the former will be given preference because of the more immediate applicability of experimental work to metrology, Proposals from workers at the assistant and associate professor level who have some record of accomplishment are especially encouraged in view of the comparative difficulty aspiring researchers have in obtaining funds.

Typical projects which have been funded through the NIST Precision Measurement Grants Program include:

(1) A test of local Lorentz invariance using polarized ^{21}Ne nuclei, T.E. Chupp, Harvard University.

(2) A new method to search for an electric dipole moment of the electron, L.R. Hunter, Amherst College.

(3) High-precision timing of millisecond pulsars, D.R. Stinebring, Princeton University.

(4) Development of an atom interferometer gyroscope for tests of general relativity, M. Kasevich, Stanford University.

(5) Spectroscopy of francium: towards a precise parity nonconservation measurement in a laser trap, Luis A. Orozco, State University of New York at Stony Brook.

(6) Measurement of the magnetically-induced QED birefringence of the vacuum, Siu Au Lee, Colorado State University.

(7) Measurement of Newton's constant *G* using a new method, J.H. Gundlach, University of Washington.

(8) Measurement of the polarization of the cosmic microwave background, S.T. Staggs, Princeton University.

Eligibility: Eligible applicants are institutions of higher education, other non-profits, commercial organizations, international organizations, state, local and Indian tribal governments and Federal agencies. Applications from non-Federal and Federal applicants will be competed against each other. Proposals selected for funding from non-Federal applicants will be funded through a project grant or cooperative agreement under the terms of this notice. Proposals selected for funding from non-NIST Federal agencies will be funded through an interagency transfer. Please Note: Before non-NIST Federal applicants may be funded, they must demonstrate that they have legal authority to receive funds from another federal agency in excess of their appropriation. As this announcement is not proposing to procure goods or services from applicants, the Economy Act (31 U.S.C. 1535) is not an appropriate legal basis.

Funding Availability: For the *Precision Measurement Grants Program*, the annual budget is approximately $300,000. Two new grants in the amount of $50,000 per year will be awarded; the remaining $200,000 will fund continuing grants. Applicants must propose multi-year projects, not to exceed three (3) years. The scope of work must be clearly severable into annual increments of meaningful work that represent solid accomplishments in case continued funding is not made available to the applicant. Because of commitments for supporting multi-year programs, only a portion of the budget is available to initiate new programs or continue existing ones in any one year.

Proposal Review Process and Evaluation Criteria: For the *Precision Measurement Grants Program*, to simplify the proposal writing and evaluation process, the following selection procedure will be used:

Applicants will initially submit abbreviated proposals and these will be reviewed on the basis of the evaluation criteria given below. The NIST Precision Measurement Grants Committee and an Outside Review Committee will then select approximately four to eight semifinalists and request that these candidates submit full proposals. The same committees will evaluate the detailed proposals based on the same evaluation criteria. In making recommendations for funding, the program's selecting official will take into consideration the results of the evaluations, the extent to which the proposed research would support NIST's understanding, improvement, or development of measurement methods or physical standards, and his or her judgment as to which applications, when the slate is taken as a whole, are likely to best further the objectives of the NIST Precision Measurements Grants Program, as described above in the Program Description and Objectives section. Two grantees for fiscal year 2002 will be selected. The final approval of selected applications and award of grants or cooperative agreements will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final.

The evaluation criteria to be used in evaluating the abbreviated application proposals and full proposals are:

1. The importance of the proposed research—Does it have the potential of answering some currently pressing question or of opening up a whole new area of activity?

2. The relationship of the proposed research to NIST's ongoing work—Will it support one of NIST's current efforts to develop a new or improved fundamental measurement method or physical standard, or to better understand an important, but already existing, measurement method or physical standard?

3. The feasibility of the research—Is it likely that significant progress can be made in a three year time period with the funds and personnel available?

4. The past accomplishments of the applicant—Is the quality of the research previously carried out by the prospective grantee such that there is a high probability that the proposed research will be successfully carried out?

Each of these factors is given equal weight in the evaluation process.

Award Period: For the Precision Measurement Grants Program, NIST is now accepting applications for two new grants in the amount of $50,000 per year to be awarded for the period October 1, 2001, through September 30, 2002 (fiscal year 2002). Each award may be continued for up to two additional years; however, future or continued funding will be at the discretion of NIST based on satisfactory performance, continuing relevance to program objectives, and the availability of funds.

Matching Requirements: The Precision Measurement Grants Program does not require any matching funds.

Application Kit: For the Precision Measurement Grants Program, an application kit, containing all required application forms and certifications, is available by contacting Ms. Michelle Hane, (301) 975–4397.

PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs

Dates: The PL, MSEL, MEL, ITL, BRFL, and EEEL SURF Programs proposals must be received no later than the close of business February 15, 2001.

Addresses: For the PL, MSEL, MEL, ITL, BFRI, and EEEL SURF Programs, applicant institutions must submit one signed original and two (2) copies of the proposal to: Attn.: Ms. Anita Sweigert, National Institute of Standards and Technology; 100 Bureau Drive, Stop 8400, Gaithersburg, MD 20899–8400, Tel: (301) 975–4200, E-Mail: anita.sweigert@nist.gov, Website: http://www.surf.nist.gov

Technical questions for the PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs should be directed to the following contact persons: for the PL SURF Program, Dr. Marc Desrosiers, Tel: (301) 975–5639, E-mail: marc.desrosiers@nist.gov; for the MSEL SURF Program, Dr. Terrell A. Vanderah, Tel: (301) 975–5785, E-mail: terrell.vanderah@nist.gov; for the MEL SURF Program, Ms. Lisa Jean Fronczek, Tel: (301) 975–6633, E-mail: *lfronczek@nist.gov:* for the ITL SURF Program, Dr. Larry Reeker, Tel: (301) 975–5147, E-mail: *larry.reeker@nist.gov:* for the BFRL SURF Program, Dr. Chris White, Tel: (301) 975–6016, E-mail: *cwhite@nist.gov:* and for the EEEL SURF Program, Dr. David Newell, Tel: (301) 975–4228, E-mail: david.newell@nist.gov.

Authority: The authority for the PL, MSEL, MEL, ITL, BFRL and EEEL SURF Programs is as follows: 15 U.S.C. 278g–l sizes NIST to fund financial assistance awards to students at institutions of higher learning within the United States. These students must show promise as present or future contributors to the missions of NIST. Cooperative agreements are awarded to assure continued growth and progress of science and engineering in the United States, including the encouragement of women and minority students to continue their professional development.

Program Description and Objectives: The program description and objectives for the PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs are as follows: To build a mutual beneficial relationship between the student, the institution of higher learning, and NIST. This is the ninth year of the PL SURF Program, which is partially funded by the NSF Physics Division as a Research Experience for Undergraduates (REU) site. This is the fourth year of the MSEL SURF Program funded by the NSF Division of Materials Research (DMR) as a Research Experience for Undergraduates (REU) site. This is the third year of the MEL SURF Program funded by the NSF Division of Engineering Education and Centers (EEC) as a Research Experience for Undergraduates (REU) site. This is the first year of the ITL, BFRL, and EEEL SURF Programs. Less than ten percent of the associated student subsistence, travel and lodging has been provided in costs sharing by the participating institutions in previous years.

NIST is one of the nation's premiere research institutions for the physical and engineering sciences and, as the lead Federal agency for technology transfer, provides a strong interface between government, industry and academia. NIST embodies a special science culture, developed from a large and well-equipped research staff that enthusiastically blends programs that address the immediate needs of industry with longer-term research that anticipates future needs. This occurs in few other places and enables the Physics Laboratory, the Materials Science and Engineering Laboratory, the Manufacturing Engineering Laboratory, the Information Technology Laboratory, the Building and Fire Laboratory, and the Electronics and Electrical Engineering Laboratory to offer unique research and training opportunities for undergraduates, providing them a research-rich environment and exposure to state of the art equipment.

Attending to the long-term needs of many U.S. high-technology industries, NIST's Physics Laboratory conducts basic research in the areas of quantum, electron, optical, atomic, molecular, and radiation physics. To achieve these goals, PL staff develop and utilize highly specialized equipment, such as polarized electron microscopes, scanning tunneling microscopes, lasers, and x-ray and synchrontron radiation sources. Research projects can be theoretical or experimental and will range in focus from computer modeling of fundamental processes through trapping atoms and choreographing molecular collisions, to standards for radiation therapy.

NIST's Materials Science and Engineering Laboratory conducts basic research in the electronic, magnetic, optical, superconducting, mechanical, thermal, chemical, and structural properties of metals, ceramics, polymers, and composites. Much of this applied research is devoted to overcoming barriers to the next technological revolution, in which individual atoms and molecules will serve as the fundamental building blocks of devices. Preparation of unique materials by atomic level tailoring of multi-layers, perfect single crystals, and nanocomposites are just some of the future technologies being developed and explored in NIST's MSEL. To achieve these goals, staff develop and utilize highly specialized equipment, such as high resolution electron microscopes, atomic force microscopes, neutron scattering instruments, x-ray diffraction sources, lasers, magnetometers, plasma furnaces, melt spinners, molecular beam epitaxy systems, and thermal spray systems. Research projects can be theoretical or experimental and will range in focus from the structural, chemical, and morphological characterization of advanced materials made in the NIST laboratories to the accurate measurement of the unique properties possessed by these special materials.

NIST's Manufacturing Engineering Laboratory conducts theoretical and experimental research in length, mass, force, vibration, acoustics, and ultrasonics, as well as intelligent machines, precision control of machine tools, information technology for the integration of all elements of a product's life cycle. Much of this applied research is devoted to overcoming barriers to the next technological revolution, in which manufacturing facilities are spread across the globe. MEL's research and development leads to standards, test

methods and data that are crucial to industry's success in exploiting advanced manufacturing technology. Critical components of manufacturing at any level are measurement and measurement-related standards, not just of products, but increasingly of information about products and processes. Thus, MEL programs enhance both physical and information-based measurements and standards. Research projects can be theoretical or experimental, and will range in focus from intelligent machine control, characterizing a manufacturing process or improving product data exchange, to the accurate measurement of an artifact's dimensions.

NIST's Information Technology Laboratory responds to industry and user needs for objective, neutral tests for information technology. These are enabling tools that help companies produce the next generation of products and services, and that help industries and individuals use these complex products and services. ITL works with industry, research and government organizations to develop and demonstrate tests, test methods, reference data, proof of concept implementations and other infrastructural technologies. Program activities include: high performance computing and communications systems; emerging network technologies; access to, exchange, and retrieval of complex information; computational and statistical methods; information security; and testing tools and methods to improve the quality of software.

NIST's Building and Fire Research Laboratory provides technical leadership and participates in developing the measurement and standards infrastructure related to materials critical to U.S. industry, academia, government, and the public. Building and Fire Research programs at NIST cover a full range of materials issues from design to processing to performance. Separate research initiatives address concrete, coating, earthquake resistance of structures, fire science and engineering, the theory and modeling of materials, and materials reliability. Through laboratory-organized consortia and one-on-one collaborations, BFRL's scientists and engineers work closely with industrial researchers, manufacturers of high-technology products, and the major users of advanced materials.

NIST's Electronics and Electrical Engineering Laboratory strives to be the world's best source of fundamental and industrial-reference measurement methods and physical standards for electrotechnology. To be a world-class resource for semiconductor measurements, data, models, and standards focused on enhancing U.S. technological competitiveness in the world market, research is conducted in semiconductor materials, processing, devices, and integrated circuits to provide, through both experimental and theoretical work, the necessary basis for understanding measurement-related requirements in semiconductor technology. To provide the world's most technically advanced and fundamentally sound basis for all electrical measurements in the United States, research projects include maintaining and disseminating the national electrical standards, developing the measurement methods and services needed to support electrical materials, components, instruments, and systems used for the generation, transmission, and application of conducted electrical power, and related activities in support of the electronics industry including research on video technology and electronic product data exchange.

SURF students will have the opportunity to work one-on-one with our nation's top scientists and engineers. it is anticipated that successful SURF students will move from a position of reliance on guidance from their research advisors to one of research independence during the twelve-week period. One goal of this partnership is to provide opportunities for our nation's next generation of scientists and engineers to engage in world-class scientific research at NIST, especially in ground-breaking areas of emerging technologies. This carries with it the hope of motivating individuals to pursue a Ph.D. in physics, materials science, engineering, mathematics, or computer science, and to consider research careers. *SURFing the Physics Laboratory, SURFing the Materials Science and Engineering Laboratory, SURFing the Manufacturing Engineering Laboratory, SURFing the Information Technology Laboratory, SURFing the Building and Fire Research Laboratory*, and *SURFing the Electronics and Electrical Engineering Laboratory* will help to forge partnerships with NSF and with post-secondary institutions that demonstrate strong, hands-on undergraduate science curricula, especially those with a demonstrated commitment to the education of women, minorities, and students with disabilities.

Eligibility: For the *PL, MSEL, MEL, ITL, BFRL, AND EEEL SURF Programs*, colleges and universities in the United States and its territories with degree granting programs in materials science, chemistry, engineering, computer science, mathematics, or physics. Participating students must be U.S. citizens or permanent U.S. residents.

Funding Availability: For the *PL SURF Program*, the NIST Physics Laboratory will commit approximately $50,000 to support these cooperative agreements. The NIST Physics Laboratory's REU Program is anticipating renewal of funding by the NSF at the level of $70,000 per year. The anticipated direct costs for subsistence, travel, lodging, and conference attendance for twenty-five students is about $150,000. The actual number of awards made under this announcement will depend on the level of cost sharing by academic partners.

For the *MSEL SURF Program*, the NIST Materials Science and Engineering Laboratory anticipates receiving funding as a NSF REU Program at the level of $50,000 per year. For the *MEL SURF Program*, the NIST Manufacturing Engineering Laboratory anticipates receiving funding as a NSF REU Program at the level of $52,000 per year. For the *ITL SURF Program*, the NIST Information Technology Laboratory anticipates receiving funding as a NSF REU Program at the level of $50,000 per year. For the *BFRL SURF Program,* the NIST Building and Fire Laboratory anticipates receiving funding as a NSF REU Program at the level of $50,000 per year. for the *EEEL SURF Program,* the NIST Electronics and Electrical Engineering Laboratory anticipates receiving funding as a NSF REU Program at the level of $50,000 per year. It is anticipated that the funding for the *MSEL, MEL, ITLBFRL, and EEEL SURF Programs* will provide for the costs of subsistence, travel and lodging, and the conference attendance of eight students for each program. The actual number of awards made under this announcement will depend on the level of cost sharing by academic partners.

For all SURF Programs described in this notice, it is expected that individual awards to institutions will range from approximately $3,000 to $70,000.

Proposal Review Process and Evaluation Criteria: The PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs conduct an initial screening of all proposals received by the deadline for incomplete or non-responsive applications, which will be returned to the applicants. All proposals will then be reviewed and ranked by a panel of three NIST scientists appointed by the Program Directors on the basis of the evaluation criteria. Proposals should include the following:

(A) Student Information:

(1) student application information cover sheet:

(2) official transcript for each student nominated for participation (students must have a recommended G.P.A. of 3.0 or better, out of a possible 4.0);

(3) a personal statement from each student and statement of commitment to participate in the 2001 SURF program, including a description of the student's prioritized research interests;

(4) a resume for each student; and

(5) two letters of recommendation for each student.

(B) Information About the Applicant Institution:

(1) description of the institution's education and research philosophy, faculty interests, on-campus research program(s) and opportunities, and overlapping research interests of NIST and the institution; and

(2) a statement addressing issues of academic credit and cost sharing.

For the PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs, the evaluation criteria are:

Evaluation of Student's Academic Ability and Commitment to Program Goals (70%): Includes, but is not limited to, evalution of the following completed course work; expressed research interest; prior research experience, grade point average in courses relevant to program, career plans, honors and activities.

Evaluation of Applicant Institution's Commitment to Program Goals (30%): Includes, but is not limited to, evaluation of the following: institution's focus on AMO physics, materials science, manufacturing research and all of its components, including but not limited to engineering, computer science, physics, electrical engineering, and mathematics; overlap between research interests of the institution and NIST; emphasis on undergraduate hands-on research; undergraduate participation in research conferences/programs; on-campus research facilities; part participation by students/institution in such programs; and commitment to educate women, minorities, and persons with disabilities. In the spirit of a true partnership, successful applicant institutions will be encouraged to contribute some partial support to the program. A suggested level of participation would be: to directly cover (partially or entirely) student travel (one round trip common carrier) or lodging costs (approximately $2,200); total coverage of indirect costs and/or fringe benefits (NIST will not authorize funds for indirect costs of fringe benefits); a stated intent to support the participating student(s) at a research conference; and/or awarding of academic credit for the student research.

In recommending applications for funding, the program's selecting official will take into consideration the results of the panel's evaluations, including rank, the program objectives of the NIST laboratories as described above, and the selecting official's judgment as to which applications, when the slate is taken as a whole, are likely to best further the goals of the SURF Program. The level of cost sharing will not be considered in the award decision. The final approval of selected applications and award of cooperative agreements will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final.

Award Period: For the PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs these programs are anticipated to run between May 21 through August 10, 2001; adjustments may be made to accommodate specific academic schedules (e.g., a limited number of 10-week cooperative agreements).

Matching Requirements: The PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs encourage, but do not require, cost sharing.

Application Kit: For the PL, MSEL, MEL, ITL, BFRL, and EEEL SURF Programs, an application kit, containing all required forms and certifications, may be obtained by contacting Ms. Anita Sweigert, (301) 975–4200; websites for each program's application kit may be accessed through the following website: *http://www.surf.nist.gov.*

MSEL Grants Program

Dates: The MSEL Grants Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds. Each applicant must submit one signed original and two copies of each proposal along with a Grant Application. (Standard Form 424 REV. 7/97 and other required forms).

Addresses: For the MSEL Grants Program, submit one signed original and two copies of the proposal, clearly marked to identify the field of research to: Materials Science and Engineering Laboratory, Attn: Ms. Marlene Taylor, National Institute of Standards and Technology, 100 Bureau Drive, Stop 8501, Building 223, Room A305, Gaithersburg, Maryland 20899–8501, Tel: (301) 975–5653, E-mail: marlene.taylor@nist.gov.

Authority: The authority for the *MSEL Grants Program* is as follows: As authorized under 15 U.S.C. 272(b) and (c), the MSEL conducts a basic and applied research program directly and through grants and cooperative agreements to eligible recipients.

Program Description and Objectives: All proposals submitted to the MSEL Grants Program must be in accordance with the program objectives listed below. The appropriate Program Manager for each field of research may be contacted for clarification of the program objectives.

I. Ceramics Division, 852—The primary objective is to supplement division activities in the area of ceramic processing, tribology, composites, machining, interfacial chemistry, and microstructural analysis. The contact person for this division is: Dr. Ronald Munro and he may be reached at (301) 975–6127 or by e-mail at ronald.munro@nist.gov.

II. Polymers Division, 854—The primary objective is to support division programs in electronic materials, biomaterials, multiphase materials and processing characterization through participation in research on metrology, synthesis, processing and characterization of structure, mechanical, thermal and electrical properties. The contact person for this division is: Dr. Bruno Fanconi and he may be reached at (301) 975–6769 or by e-mail at bruno.fanconi@nist.gov.

III. Metallurgy Division, 855—The primary objective is to develop techniques to predict, measure and control transformations, phases, microstructure and kinetic processes as well as mechanical, physical and chemical properties in metals and their alloys. The contact person for this division is: Dr. Robert Schaefer and he may be reached at (301) 975–5961 or by e-mail at robert.schaefer@nist.gov.

IV. NIST Center for Neutron Research, 856—The primary objective is to develop high resolution cold and thermal neutron scattering research approaches and related physics, chemistry, macromolecular and materials applications. The contact person for this division is: Dr. John J. Rush and he may be reached at (301) 975–6231 or by e-mail at john.rush@nist.gov.

Eligibility: The MSEL Grants Program will be open to institutions of higher

education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations.

Funding Availability: In fiscal year 2001, the MSEL Grants Program anticipates funding of approximately $2,500,000, including new awards and continuing projects. Most grants and cooperative agreements are expected to be in the $25,000 to $100,000 per year range.

Proposal Review Process and Evaluation Criteria: For the MSEL Grants Program proposals will be reviewed in a two-step process. First, at least three independent, objective individuals knowledgeable about the particular scientific area described in the section above that the proposal addresses will conduct a technical review of proposals, as they are received on a rolling basis, based on the evaluation criteria. Second, the Division Chief or Center Director will make application selections. In making application selections, the Division Chief or Center Director will take into consideration the results of the reviewer's evaluations, the compatibility of the applicant's proposal with the program objectives of the particular division or center that the proposal addresses, and the Division Chief or Center Director's judgment as to whether the application is likely to further the objectives of the MSEL Grants Program. These objectives are described above in the ''Program Objectives'' section. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final.

For the MSEL Grants Program, the evaluation criteria the technical reviewers will use in evaluating the proposals are as follows:

1. *Rationality.* Reviewers will consider the coherence of the applicant's approach and the extent to which the proposal effectively addresses scientific and technical issues.

2. *Qualification of Technical Personnel.* Reviewers will consider the professional accomplishments, skills, and training of the proposed personnel to perform the work in the project.

3. *Resources Availability.* Reviewers will consider the extent to which the proposer has access to the necessary NIST or other facilities and overall support to accomplish project objectives.

4. *Technical Merit of Contribution.* Reviewers will consider the potential technical effectiveness of the proposal and the value it would contribute to the field of materials science and engineering and neutron research.

Each of these factors will be given equal weight in the evaluation process.

Award Period. For the MSEL Grants Program, proposals will be considered for research projects from one to three years. When a proposal for a multi-year award is approved, funding will generally be provided for only the first year of the program. If an application is selected for funding, NIST has no obligation to provide any additional funding in connection with that award. Continuation of an award to increase funding or extend the period of performance is at the total discretion of NIST. Funding for each subsequent year of a multi-year proposal will be contingent upon satisfactory progress, continued relevance to the mission of the MSEL program, and the availability of funds. The multi-year awards must have scopes of work that can be easily separated into annual increments of meaningful work that represent solid accomplishments if prospective funding is not made available to the applicant, (*i.e.,* the scopes of work for each funding period must produce identifiable and meaningful results in and of themselves).

Matching Requirements: The MSEL Grants Program does not require any matching funds.

Application Kit: For the MSEL Grants Program, an application kit, containing all required application forms and certifications is available by contacting Ms. Marlene Taylor, (303) 975–5653.

Fire Research Grants Program

Dates: The Fire Research Grants Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds.

Addresses: For the Fire Research Grants Program submit one signed original and two copies of the proposal to: Building and Fire Research Laboratory (BFRL), Attn.: Ms. Sonya Parham, National Institute of Standards and Technology, 100 Bureau Drive, Stop 8602, Gaithersburg, Maryland 20899–8602, Tel: (301) 975–6854, E-mail: *sonya.parham@nist.gov*, Website: http://www.bfrl.nist.gov.

Authority: As authorized by 15 U.S.C. 278f, the NIST Building and Fire Research Laboratory conducts directly and through grants and cooperative agreements, a basic and applied fire research program.

Program Description and Objectives: The program description and objectives for the Fire Research Grants Program are as follows:

A. *Fire Dynamics:* To develop understanding and predictive methods for dynamic fire phenomena to advance fire science and engineering practice. To perform research to understand the heat and mass transfer processes occurring in fires in order to improve predictions of the growth, spread, suppression, and emissions from fires of all scales. Experiments and metrology are developed and used to develop, support, and verify advanced computer simulations of fire phenomena, fire hazards, fire protection, and fire fighting.

B. *Large Fire Research:* To develop understanding of the behavior, prevention, and control of large fires through measurement, prediction and demonstration. This includes new understanding and technology related to: fire suppression and control, fire fighting operations, burning characteristics of assemblies, thermal and chemical emissions, smoke transport processes; fire modeling; fire investigations; fire suppression agents; use of combustion for environmental cleanup; and field measurement of both structural and unconfined fires. To perform research the results of which are used in fire fighting, fire protection, fire investigation, and construction to reduce the impact of fire on people, property, and the environment.

C. *Fire Safety Systems:* To perform research and development and demonstrate the advanced fire safety systems that utilize deterministic fire modeling. These systems are intended to enhance the quality, reliability, and accuracy of data and predictions available to quantify fire events with applications to buildings, fire protection systems, transportation systems and vehicles, training, fire fighting, fire investigations, and codes and standards. To perform research to advance the capabilities of fire models and their applications, including: developing methods to assess fire hazard and risk; creating advanced, usable models for the calculation of building fires and their effect on the environment and structure; integrating fire models with

building control and fire alarm systems, developing advanced information systems for fire fighters; developing a protocol for determining the accuracy of algorithms and comprehensive models; developing data bases to facilitate use of fire models; and advancing the concepts of performance-based engineering.

D. *Advanced Fire Measurements:* To produce the scientific basis and robust measurement methods for characterizing fires and their effluents at full- and reduced-scales. This includes discrete point, volume-integrated, and time- and space-resolved measurements for such properties as temperature, smoke density, chemical species, and flow velocity. Laboratory and computational research are also performed to understand the underpinning fire phenomena to ensure the soundness of the developed measurement techniques.

E. *Materials Fire Research*: To perform research enabling the confident development by industry of new, less-flammable materials and products. This capability is based on understanding fundamentally the mechanisms that control the ignition, flame spread and burning rate of materials, as well as and the chemical and physical characteristics that affect these aspects of flammability. This includes: developing methods of measuring the response of a material to fire conditions that enable assured prediction of the full-scale performance of the final product; developing computational molecular dynamics and other mechanistic approaches to understand flame retardant mechanisms and the effects of polymer chemical structure on flammability; characterizing the burning rates of charring and non-charring polymers and composites; and delineating and modeling the enthalpy and mass transfer mechanisms of materials combustion.

F. *Fire Sensing and Extinguishment*: To develop understanding, metrology and predictive methods to enable high-performance fire sensing and extinguishment systems; and devising new approaches to minimize the impact of unwanted fires and the suppression process. This includes: performing research for the identification and in-situ measurement of the symptoms of pending and nascent fires and the consequences of suppression; devising or adapting monitors for these variables and the intelligence for timely interpretation of the data; developing methods to characterize the performance of new approaches to fire detection and suppression; determining mechanisms for deflagration and detonation suppression by advanced agents and principles for their optimal use; and modeling the extinguishment process.

Eligibility: The Fire Research Grants Program will be open to institutions of higher education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations. Immediate family members of NIST Building and Fire Research Laboratory (BFRL) staff are ineligible for support from the Fire Research Grants Program.

Funding Availability: For the Fire Research Grants Program, the annual budget is approximately $700 thousand. Because of commitments for the support of multi-year projects, only a portion of the budget is available to initiate new programs in any one year. Most grants and cooperative agreements are in the $10,000 to $100,000 per year range.

Proposal Review Process and Evaluation Criteria: For the Fire Research Grants Program, all proposals are assigned, as received on a rolling basis, to the appropriate group leader of the six programs listed above in program description and objectives. Proposals are evaluated for technical merit based on the evaluation criteria by at least three reviewers chosen from NIST professionals, technical experts from other interested government agencies, and experts from the fire research community at large. Both the technical value of the proposal and the relationship of the work proposed to the needs of the specific program are taken into consideration in the group leader's recommendation to the Division Chief. In making the final application selections, the Division Chief will take into consideration the results of the evaluations, the scores of the reviewers, the group leader's recommendation, and the Division Chief's judgment as to whether the application is likely to further the objectives of the Fire Research Grants Program, as described above. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final. Applicants should allow up to 90 days processing time.

For the Fire Research Grants Program, the technical evaluation criteria includes the following:

a. *Technical quality of the research.* Reviewers will assess the rationality, innovation and imagination of the proposal and the fit to NIST's in-house fire research program. (0–35 points)

b. *Potential impact of the results.* Reviewers will assess the potential impact and the technical application of the results to our in-house programs and the fire safety community. (0–25 points)

c. *Staff and institution capability to do the work.* Reviewers will evaluate the quality of the facilities and experience of the staff to assess the likelihood of achieving the objective of the proposal. (0–20 points)

d. *Match of budget to proposed work.* Reviewers will assess the budget against the proposed work to ascertain the reasonableness of the request. (0–20 points)

Award Period: For the Fire Research Grants Program, proposals will be considered for research projects from one to three years. When a proposal for a multi-year project is approved, funding will initially be provided for only the first year of the program. If an application is selected for funding, DoC has no obligation to provide any additional future funding in connection with that award. Funding for each subsequent year of a multi-year proposal will be contingent on satisfactory progress, continuing relevance to the mission of the NIST Fire Research program, and the availability of funds.

Matching Requirements: The Fire Research Grants Program does not require any matching funds.

Application Kit: For the Fire Research Grants Program, an application kit, containing all required application forms and certifications is available by contacting Ms. Sonya Parham, (301) 975–6854, website: http://www.bfrl.nist.gov.

Physics Laboratory Grants Program

Dates: The Physics Laboratory Grants Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds.

Addresses: For the Physics Laboratory Grant Program applicants are requested to submit one signed original and two copies of the proposal clearly marked to identify the field of research to: Attn. Ms. Anita Sweigert, National Institute of Standards and Technology, 100 Bureau

Drive, Stop 8400, Gaithersburg, MD. 20899–8400, Tel (301) 975–4200, E-Mail: *anita.sweigert@nist.gov.*

Authority: As authorized under 15 U.S.C. 272 (b) and (c), the Physics Laboratory conducts a basic and applied research program directly and through grants and cooperative agreements to eligible recipients.

Program Description and Objectives: All proposals submitted to the Physics Laboratory Grants Program must be in accordance with the program objectives listed below. The appropriate Program Manager for each field of research may be contacted for clarification of the program objectives.

I. Electron and Optical Physics Division, 841—The primary objective is to supplement division activities in characterization of nanometer-scale electronic and magnetic structures, characterization of EUV optical components to support semiconductor lithography and ultraviolent radiometric metrology. The contact person for this division is: Dr. Charles W. Clark and he may be reached at (301) 975–3709.

II. Atomic Physics Division, 842—The primary objective is to support division programs aimed at determining basic atomic properties and developing new metrology techniques in atomic spectroscopy, quantum processes, plasma radiation, laser cooling and trapping, and quantum metrology. The contact person for this division is: Dr. Wolfgang L. Wiese and he may be reached at (301) 975–3200.

III. Optical Technology Division, 844—The primary objective is to develop improve and maintain national standards for radiation thermometry, spectroradiometry, photometry, and spectrophotometry as well as conduct basic theoretical and experimental research on the photophysical and photochemical properties of materials, in radiometric and spectroscopic techniques and instrumentation, and in the application of optical technologies. The contact person for this division is: Dr. Albert C. Parr and he may be reached at (301) 975–2316.

IV. Ionizing Radiation Division, 846—The primary objective is to provide primary standards and measurement methods and technology to support the division's work in meeting national needs in radiation interactions and dosimetry, neutron interactions, dosimetry and radioactivity including both theoretical/experimental and applied research programs. The contact person for this division is: Dr. Bert M. Coursey and he may be reached at (301) 975–5584.

V. Time and Frequency Division, 847—The primary objective is to supplement division basic and applied research programs in the areas of phase noise measurements, network synchronization, ion storage, atomic standards and optical frequency measurements in support of future standards, dissemination services, and measurement methods. The contact person for this division is: Dr. Donald B. Sullivan and he may be reached at (303) 497–3772.

Eligibility: The Physics Laboratory Grants Program will be open to institutions of higher education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations.

Funding Availability: In fiscal year 2001, the Physics Laboratory anticipates funding of approximately $1,400,000, which may be increased to approximately $2,000,000 should additional funding become available, including new awards and continuing projects. Individual awards are expected to range from approximately $5,000 to $250,000.

Proposal Review Process and Evaluation Criteria: For the Physics Laboratory Grants Program, proposals will be reviewed in a two-step process. First, at least three independent, objective individuals knowledgeable about the particular scientific area described in the section above that the proposal addresses will conduct a technical review of each proposal, based on the evaluation criteria described below. Reviews will be conducted on a monthly basis, and all proposals received during the month will be ranked based on the reviewers' scores. Second, the Division Chief will make final application selections. In making application selections, the Division Chief will take into consideration the results of the reviewers' evaluations, the compatibility of the applicant's proposal with the program objectives of the particular division or center that the proposal addresses, and the Division Chief's judgment as to whether the application is likely to further the objectives of the Physics Laboratory Grants Program. These objectives are described above in the ''Program Objectives'' section. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decisions of the Grants Officer are final.

For the Physics Laboratory Grants Program, the evaluation criteria the technical reviewers will use in evaluating the proposals are as follows:

1. *Rationality.* Reviewers will consider the coherence of the applicant's approach and the extent to which the proposal effectively addresses scientific and technical issues.

2. *Qualifications of Technical Personnel.* Reviewers will consider the professional accomplishments, skills,and training of the proposed personnel to perform the work in the project.

3. *Resources Availability.* Reviewers will consider the extent to which the proposer has access to the necessary NIST or other facilities and overall support to accomplish project objectives.

4. *Technical Merit of Contribution.* Reviewers will consider the potential technical effectiveness of the proposal and the value it would contribute to the field of physics.

Each of these factors will be given equal weight in the evaluation process.

Award Period: For the Physics Laboratory Grant Program, proposals will be considered for research projects from one to three years. When a proposal for a multi-year project is approved, funding will generally be provided for only the first year of the program. If an application is selected for funding, NIST has no obligation to provide any additional funding in connection with that award. Continuation of award to increase funding or extend the period of performance is at the total discretion of NIST. Funding for each subsequent year of a multi-year proposal will be contingent upon satisfactory progress, continued relevance to the mission of the Physics Laboratory program, and the availability of funds. The multi-year awards must have scopes of work that can be easily separated into annual increments of meaningful work that represent solid accomplishments if prospective funding is not made available to the applicant, (*i.e.*, the scopes of work for each funding period must produce the identifiable and meaningful results in and of themselves).

Matching Requirements: The Physics Laboratory Grants Program does not require any matching funds.

Application Kit: For the Physics Laboratory Grants Program, an application kit, containing all required

application forms and certifications is available by contacting Ms. Anita Sweigert, (301) 975–4201.

Chemical Science and Technology Laboratory Grants Program

Dates: The Chemical Science and Technology Laboratory Grant Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds.

Addresses: For the Chemical Science and Technology Laboratory Grant Program applicants are requested to submit one signed original and two copies of the proposal clearly marked to identify the field of research to: Attn. Dr. William F. Koch, National Institute of Standards and Technology, 100 Bureau Drive, Stop 8300, Gaithersburg, MD. 20899–8300, Tel (301) 975–8301, E–Mail: *william.koch@nist.gov*.

Authority: As authorized under 15 U.S.C. 272(b) and (c), the Chemical Science and Technology Laboratory conducts a basic and applied research program directly and through grants and cooperative agreements to eligible recipients.

Program Description and Objectives: All proposals submitted to the Chemical Science and Technology Laboratory Grants Program must be in accordance with the program objectives listed below. The appropriate Program Manager for each field of research may be contacted for clarification of the program objectives.

I. Biotechnology Division, 831—The primary objective is to advance the commercialization of biotechnology by developing the scientific/engineering technical base, reliable measurements, standards, data and models to enable U.S. industry to quickly and economically produce biochemical products with appropriate quality control. The contact person for this division is: Dr. Gary L. Gilliland, and he may be reached at (301) 975–2629.

II. Process Measurement Division, 836—The primary objective is to develop and provide measurement standards and services, measurement techniques, recommended practices, sensing technology, instrumentation, and mathematical models required for analysis, control, and optimization of industrial processes. The Division's research seeks fundamental understanding of, and generates key data pertinent to, chemical process technology. These efforts include the development and validation of data-predictive computational tools and correlation's, computer simulations of processing operations, and provision of requisite chemical, physical, and engineering data. The contact person for this division is: Dr. James R. Whetstone, and he may be reached at (301) 975–2609.

III. Surface and Microanalysis Science Division, 837—The primary objective is to promote U.S. economic growth, safety, health, and environmental quality by working with industry, other government agencies, and standards organizations to develop and apply key technologies, measurements, and standards for spatially and temporally resolved chemical characterization. The contact person for this division is: Dr. Richard R. Cavanagh, and he may be reached at (301) 975–2368.

IV. Physical and Chemical Properties Division, 838—The primary objective is to be the Nation's reference laboratory for measurements, standards, data, and models for, the thermophysical and thermochemical properties of gases, liquids, and solids—both pure materials and mixtures. The rates and mechanisms of chemical reactions in the gas and liquid phases, fluid-based physical processes and systems, including separations, low-temperature refrigeration, and low-temperature heat transfer and flow. The contact person for this division is: Dr. Mickey Haynes, and he may be reached at (303) 497–3247.

V. Analytical Chemistry Division, 839—The primary objective is to serve as the Nation's reference laboratory for chemical measurements and standards to enhance U.S. industry's productivity and competitiveness, assure equity in trade, and provide quality assurance for chemical measurements used for assessing and improving public health, safety, and the environment. The contact person for this division is: Dr. Willie E. May, and he may be reached at (301) 975–3108.

Eligibility: The Chemical Science and Technology Laboratory Grants Program will be open to institutions of higher education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations.

Funding Availability: In fiscal year 2001, the Chemical Science and Technology Laboratory anticipates funding of approximately $1,000,000. Individual awards are expected to range from approximately $5,000 to $100,000.

Proposal Review Process and Evaluation Criteria: For the Chemical Science and Technology Laboratory Grants Program, proposals will be reviewed in a two-step process. First, at least three independent, objective individuals knowledgeable about the particular scientific area described in the section above that the proposal addresses will conduct a technical review of each proposal, based on the evaluation criteria described below. Reviews will be conducted on a monthly basis, and all proposals received during the month will be ranked based on the reviewers' scores. Second, the Division Chief will make application selections. In making application selections, the Division Chief will take into consideration the results of the reviewers' evaluations, the compatibility of the applicants' proposal with the program objectives of the particular division or center that the proposal addresses, and the Division Chief's judgment as to whether the application is likely to further the objectives of the Chemical Science and Technology Laboratory Grants Program. These objectives are described above in the ''Program Objectives'' section. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decisions of the Grants Officer are final.

For the Chemical Science and Technology Laboratory Grants Program, the evaluation criteria the technical reviewers will use in evaluating the proposals are as follows:

1. *Rationality.* Reviewers will consider the coherence of the applicant's approach and the extent to which the proposal effectively addresses scientific and technical issues.

2. *Qualifications of Technical Personnel.* Reviewers will consider the professional accomplishments, skills, and training of the proposed personnel to perform the work in the project.

3. *Resources Availability.* Reviewers will consider the extent to which the proposer has access to the necessary NIST or other facilities and overall support to accomplish project objectives.

4. *Technical Merit of Contribution.* Reviewers will consider the potential technical effectiveness of the proposal and the value it would contribute to the field of chemistry.

Each of these factors will be given equal weight in the evaluation process.

Award Period: For the Chemical Science and Technology Laboratory Grant Program, proposals will be considered for research projects from one to three years. When a proposal for a multi-year award is approved, funding will generally be provided for only the first year of the program. If an application is selected for funding, NIST has no obligation to provide any additional funding in connection with that award. Continuation of an award to increase funding or extend the period of performance is at the total discretion of NIST. Funding for each subsequent year of a multi-year proposal will be contingent upon satisfactory progress continued relevance to the mission of the Chemical Science and Technology Laboratory program, and the availability of funds. The multi-year awards must have scopes of work that can be easily separated into annual increments of meaningful work that represent solid accomplishments if prospective funding is not made available to the applicant (*i.e.* the scopes of work for each funding period must produce identifiable and meaningful results in and of themselves).

Matching Requirements: The Chemical Science and Technology Laboratory Grants Program does not require any matching funds.

Contact: For information on the Chemical Science and Technology Laboratory Grants Program, please contact Dr. William Koch, (301) 975–8301.

Manufacturing Engineering Laboratory (MEL) Grants Program

Dates: The MEL Grants Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds. Each applicant must submit one signed original and two copies of each proposal along with a Grant Application (Standard Form 424 REV. 7/97 and other required forms).

Addresses: For the MEL Grants Program, submit one signed original and two copies of the proposal, clearly marked to identify the field of research, to: Manufacturing Engineering Laboratory, Attn: Mrs. Barbara Horner, National Institute of Standards and Technology, 100 Bureau Drive, Stop 8200, Building 220, Room B322, Gaithersburg, Maryland 20899–8200, Tel: (301) 975–3400, E-mail: *barbara.horner@nist.gov.*

Authority: As authorized under 15 U.S.C. 272(b) and (c), the MEL conducts a basic and applied research program directly and through grants and cooperative agreements to eligible recipients.

Program Description and Objectives: All proposals submitted must be in accordance with the program objectives listed below. The appropriate Program Manager for each field of research may be contacted for clarification of the program objectives.

I. Precision Engineering Division, 821—The primary objective is to support laboratory programs in the areas of Engineering Metrology, Large-Scale Metrology, Nanometer-Scale Metrology, and Surface Metrology. The contact person for this division is: Dr. Dennis Swyt, and he may be reached at (301) 975–3463; dennis.swyt@nist.gov.

II. Manufacturing Metrology Division, 822—The primary objective is to support laboratory programs in Machining Systems; Mechanical Metrology; Advanced Optics Metrology; and Sensors, Interfaces, Predictive Process Engineering; and Networks for Metrology and Manufacturing. The contact person for this division is: Dr. E. Clayton Teague, and he may be reached at (301) 975–6600; clayton.teague@nist.gov.

III. Intelligent Systems Division, 823—The primary objective is to support laboratory programs in Intelligent Open Architecture Control of Manufacturing Systems, Intelligent Controls of Mobility Systems, and Intelligent Systems. The contact person for this division is: Dr. John M. Evans, and he may be reached at (301) 975–3418; j.evans@nist.gov.

IV. Manufacturing Systems Integration Division, 826—The primary objective is to support laboratory programs in Information Technology Metrology for Manufacturing, Manufacturing Enterprise Engineering, Manufacturing Simulation and Visualization, Product Engineering, and Nano-manufacturing. The contact person for this division is: Dr. Steven R. Ray, and he may be reached at (301) 975–3508; steven.ray@nist.gov.

Eligibility: The MEL Grants Program will be open to institutions of higher education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations.

Funding Availability: In fiscal year 2001, MEL Grants Program anticipates funding of approximately $750,000, including new awards and continuing projects. Individual awards are expected to range from approximately $25,000 to $300,000.

Proposal Preview and Evaluation Criteria: The MEL Grants Program will conduct an initial screening for incomplete or non-responsive applications, which will be returned to the applicants. Proposals will then be reviewed in a two-step process. First, at least three independent, objective individuals knowledgeable about the particular scientific area described in the section above that the proposal addresses will conduct a technical review of proposals, based on the evaluation criteria described below. Reviews will be conducted no less than once per quarter, and all proposals since the last review session will be ranked based on the reviewers' scores. Second, the Division Chief or Laboratory Director will make application selections. In making application selections, the Division Chief or Laboratory Director will take into consideration the results of the reviewers' evaluations, the compatibility of the applicant's proposal with the program objectives of the particular division that the proposal addresses, and the Division Chief's or Laboratory Director's judgment as to whether the application is likely to further the objectives of the MEL Grants Program. These objectives are described above in the Program Objectives. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final.

For the MEL Grants Program, the evaluation criteria the technical reviewers will use in evaluating the proposals are as follows:

1. *Rationality.* Reviewers will consider the coherence of the applicant's approach and the extent to which the proposal effectively addresses scientific and technical issues.

2. *Technical Merit of Contribution.* Reviewers will consider the potential technical effectiveness of the proposal and the value it would contribute to the field of manufacturing engineering and metrology research.

3. *Qualifications of Technical Personnel.* Reviewers will consider the professional accomplishments, skills, and training of the proposed personnel to perform the work in the project.

4. *Resources Availability.* Reviewers will consider the extent to which the proposer has access to the necessary NIST or other facilities and overall support to accomplish project objectives.

Each of these factors will be given equal weight in the evaluation process.

Award Period: For the MEL Grants Program, proposals will be considered for research projects from one to three years. When a proposal for a multi-year award is approved, funding will generally be provided for only the first year of the program. If an application is selected for funding, NIST has no obligation to provide any additional funding in connection with that award. Continuation of an award to increase funding or extend the period of performance is at the total discretion of NIST. Funding for each subsequent year of a multi-year proposal will be contingent upon satisfactory progress, continued relevance to the mission of the MEL program, and the availability of funds. The multi-year awards must have scopes of work that can be easily separated into annual increments of meaningful work that represent solid accomplishments if prospective funding is not made available to the applicant, (*i.e.,* the scopes of work for each funding period must produce identifiable and meaningful results in and of themselves).

Matching Requirements: The MEL Grants Program does not require any matching funds.

Application Kit: An application kit, containing all required application forms and certifications is available by electronic mail to: Mrs. Barbara Horner, *barbara.horner@nist.gov.* Alternatively, Mrs. Horner can be contacted at (301) 975–3400.

Electronics and Electrical Engineering (EEEL) Grants Program

Dates: The Electronics and Electrical Engineering Grants Program proposals must be received no later than the close of business September 30, 2001. Proposals received after June 30, 2001 will continue to be processed and considered for funding but may be funded in the next fiscal year, subject to the availability of funds.

Addresses: For the Electronics and Electrical Engineering Grants Program, submit one signed original and two copies of the proposal package to: Electronics and Electrical Engineering Laboratory, Attn.: D.J. Hamilton, National Institute of Standards and Technology, 100 Bureau Drive, Stop 8100, Gaithersburg, MD 20899–8100, Tel.: (301) 975–2227, Fax: (301) 975–4091.

Authority: As authorized by 15 U.S.C. 272(b) and (c), the NIST Electronnics and Electrical Engineering Laboratory conducts a basic and applied research program directly and through grants and cooperative agreements to eligible recipients.

Program Description and Objectives: The Electronics and Electrical Engineering Grants Program solicits proposals in support of the broad program objectives identified below.

The Electronics and Electrical Engineering Grants Program supports the formal mission of the associated Laboratory: The Electronics and Electrical Engineering Laboratory promotes U.S. economic growth by providing measurement capability of high impact focused primarily on the critical needs of the U.S. electronics and electrical industries, and their customers and suppliers.

More specifically, the Electronics and Electrical Engineering Grants Program solicits proposals to support specific programs in the areas of metrology for semiconductors (including mainstream silicon, power devices, and compound semiconductors), superconductors (including cryoelectronics and bulk superconductors), electronic instrumentation, radio-frquency technology (including microwave and millimeter-wave, antennas, and electromagnetic compatibility/interference), optoelectronics, magnetics (including bulk magnetic materials and magnetic data storage), video (including flat-panel displays), electronic commerce as applied to electronic products and devices, the transmission and distribution of electrical power, national electrical standards (fundamental, generally quantum-based physical standards), and law enforcement (clothing, communication systems, emergency equipment, investigative aids, protective equipment, security systems, vehicles, speed-measuring equipment, weapons, and analytical techniques and standard reference materials used by the public safety community).

For details on these various activities, please see the Electronics and Electrical Engineering Laboratory website at *http://www.eeel.nist.gov.* Note that documents describing the current programs for the five technical divisions and two offices are available through the home page.

Technical contacts for these areas are:

Semiconductors

Semiconductor Electronics Division—Division Chief: Dr. David G. Seiler; (301) 975–2054; *david.seiler@nist.gov*

Office of Microelectronics Programs—Director: Dr. Stephen Knight; (301) 975–4400; *stephen.knight@nist.gov*

Superconductors (bulk); Magnetics

Laboratory Acting Deputy Director: Dr. Alan H. Cookson; (301) 975–2220; *alan. cooson@nist.gov*

Superconductors (cryoelectronics); National electrical standards (Josephson array development)

Electromagneteic Technology Division—Division Chief: Dr. Richard E. Harris; (303) 497–3678; *richard.harris@boulder.nist.gov*

Electronic instrumentation; Video; Electronic commerce; National electrical standards (other than Josephson array development)

Electricity Division—Division Chief: Dr. Bruce F. Field; (301) 975–2400; *bruce.field@nsit.gov*

Radio-frequency technology

Radio-Frequency Technology Division—Division Chief: Dr. Dennis S. Friday; (303) 497–3132; Friday@boulder.nist.gov

Optoelectronics

Optoelectronics Division; Office of Optoelectronics Programs—Division Chief and Office Director: Dr. Gordon W. Day; (303) 497–5432; *gwday@boulder.nist.gov*

Law Enforcement

Office of Law Enforcement Standards—Director: Dr. Kathleen Higgins; (301) 975–2757; *kathleen.higgins@nist.gov*

Eligibility: The Electronics and Electrical Engineering Grants Program is open to institutions of higher education; hospitals; non-profit organizations; commercial organizations; state, local, and Indian tribal governments; foreign governments; organizations under the jurisdiction of foreign governments; and international organizations.

Funding Availability: Over the past three years, the Electronics and Electrical Engineering laboratory funded a total of approximately $1,000,000 in grants and cooperative agreements. The amount available each year fluctuates considerably based on programmatic needs. Individual awards are expected to range between $5,000 and $150,000.

Proposal Review Process and Evaluation Criteria: For the Electronics and Electrical Engineering Grants Program, proposals will be distributed to the appropriate Division Chief or Office Director based on technical area by one or more technical professionals familiar with the programs of the

Electronics and Electrical Engineering Laboratory. The Divisions and Offices will be asked to score proposals based on the following criteria and weights:

Proposal addresses specific program or project need not met (25%)
Proposal provides evidence of applicant's expertise in relevant technical area (20%)
Proposal offers innovative approach (20%)
Proposal provides realistic schedule with defined milestones (20%)
Proposal provides adequate rationale for budget (15%)

Reviews will be conducted on a monthly basis during the first quarter, and quarterly thereafter, and all proposals received during the month or quarter will be ranked based on the reviewers' scores. Based on the reviewers' scores, recommendations of with the Division Chiefs and Office Directors, the availability of funding, and the Laboratory Director's judgment as to whether the application is likely to further the objectives of the Electronics and Electrical Engineering Grants Program, as described above, the Laboratory Director will provide recommendations to the NIST Grants Officer. The final approval of selected applications and award of financial assistance will be made by the NIST Grants Officer based on compliance with application requirements as published in this notice, compliance with applicable legal and regulatory requirements, and whether the recommended applicants appear to be responsible. Applicants may be asked to modify objectives, work plans, or budgets and provide supplemental information required by the agency prior to award. The decision of the Grants Officer is final. Applicants should allow up to 90 days processing time.

Award Period: For the Electronics and Electrical Engineering Grants Program, proposals will be considered for research projects from one to three years. When an proposal for a multi-year award is approved, funding will generally be provided for only the first year of the program. If an application is selected for funding, NIST has not obligation to provide any additional funding in connection with that award. Continuation of an award to increase funding or extend the period of performance is at the total discretion of NIST. Funding for each subsequent year of a multi-year proposal will be contingent upon progress, continued relevance to the mission of the Electronics and Electrical Engineering Grants Program, and the availability of funds. The multi-year awards must have scopes of work that can be easily separated into annual increments of meaningful work that represent solid accomplishments if prospective funding is not made available to the applicant, (*i.e.,* the scopes of work for each funding period must produce identifiable and meaningful results in and of themselves).

Matching Requirements. The Electronics and Electrical Engineering Grants Program does not require any matching funds.

Application Kit: An application kit, containing all required application forms and certifications is available by contacting: D.J. Hamilton, (301) 975–2227.

Additional Information: The following information is applicable to all programs described above.

Funding Availability: For all Financial Assistance programs listed above, awards are contingent on the availability of funds.

Catalog of Federal Domestic Assistance Name and Number: Measurement and Engineering Research and Standards—11.609.

For Further Information Contact: All grants administration questions concerning these programs should be directed to the NIST Grants Office at (301) 975–5718.

Application Kit: The application kit includes the following:

SF 424 (Rev 7/97)—Application for Federal Assistance
SF 424A (Rev 7/97)—Budget Information—Non-Construction Programs, including a detailed budget narrative explaining the details of each budget category and the basis for the cost. If indirect costs are included in the budget, a copy of the applicant's negotiated indirect cost rate must be submitted, if available.
SF 424B (Rev 7/97)—Assurances—Non-Construction Programs
CD 511 (7/91)—Certification Regarding Debarment, Suspension, and Other Responsibility Matters; Drug-free Workplace Requirements and Lobbying
CD 512 (7/91)—Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transactions and Lobbying
SF–LLL—Disclosure of Lobbying Activities
CD–346—Applicant for Funding Assistance

Paperwork Reduction Act: The Standard form 424 and other Standard Forms in the application kit are subject to the requirements of the Paperwork Reduction Act and have been approved by OMB under Control No. 0348–0043, 0348–0044, 0348–0040, and 0348–0046.

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, subject to the requirements of the Paperwork Reduction Act, unless that collection of information displays a currently valid OMB Control Number.

Research Projects Involving Human Subjects, Human Tissue, Data or Recordings Involving Human Subjects: Any proposal that includes research involving human subjects, human tissue, data or recordings involving human subjects must meet the requirements of the Common Rule for the Protection of Human Subjects, codified for the Department of Commerce at 15 CFR Part 27. In addition, any proposal that includes research on these topics must be in compliance with any statutory requirements imposed upon NIH and other federal agencies regarding these topics, all regulatory policies and guidance adopted by NIH, FDA, and other federal agencies on these topics, and all Presidential statements of policy on these topics.

The NIH recently released their guidelines on the use of human pluripotent stem cells derived from human embryos in research. The NIST is currently reviewing these guidelines. Until NIST has had the opportunity to fully assess the new guidelines and develop appropriate implementing procedures, NIST will not consider proposals that involve human pluripotent stem cells derived from human embryos for funding.

On December 3, 2000, the U.S. Department of Health and Human Services (DHHS) introduced a new Federalwide Assurance of Protection of Human Subjects (FWA). The FWA covers all of an institution's Federally-supported human subjects research, and eliminates the need for other types of Assurance documents. In anticipation of the new Assurance, the Office for Human Research Protections (OHRP) has suspended processing of multiple project assurance (MPA) renewals. All existing MPAs will remain in force until further notice. OHRP will continue to accept new single project assurances (SPAs) until approximately March 1, 2001. For information about FWAs, please see the OHRP website at *http://ohrp.osophs.dhhs.gov/whatsnew.htm.*

In accordance with the DHHS change, NIST will continue to accept the submission of human subjects protocols

that have been approved by Institutional Review Boards (IRBs) possessing a current, valid MPA from DHHS. NIST also will accept the submission of human subjects protocols that have been approved by IRBs possessing a current, valid FWA from DHHS. NIST will not issue an SPA for any IRB reviewing any human subjects protocol proposed to NIST.

Research Projects Involving Vertebrate Animals: Any proposal that includes research involving vertebrate animals must be in compliance with the National Research Council's ''Guide for the Care and Use of Laboratory Animals'' which can be obtained from National Academy Press, 2101 Constitution Avenue, NW., Washington, DC 20055. In addition, such proposals must meet the requirements of the Animal Welfare Act (7 U.S.C. 2131 *et seq.*), 9 CFR parts 1, 2, and 3, and if appropriate, 21 CFR part 58. These regulations do not apply to proposed research using pre-existing images of animals or to research plans that do not include live animals that are being cared for, euthanased, or used by the project participants to accomplish research goals, teaching, or testing. These regulations also do not apply to obtaining animal materials from commercial processors of animal products or to animal cell lines or tissues from tissue banks.

Matching Funds: Although many of the programs described in this notice do not require cost share, if it is determined that your proposal falls within the authority of 19 U.S.C. 2543–45 cost share will be required as follows:

Pursuant to 19 U.S.C. 2543–45, financial assistance shall not exceed 75 percent of such program or activity, when the primary purpose of such program or activity is—

(1) To increase the awareness of proposed and adopted standards-related activities;

(2) To facilitate international trade through the appropriate international and domestic standards-related activities;

(3) To provide adequate United States representation in international standards-related activities; and

(4) To encourage United States exports through increased awareness of foreign standards-related activities that may affect United States exports.

Type of Funding Instrument: The funding instrument will be a grant or cooperative agreement, depending on the nature of the proposed work. A grant will be used unless NIST is ''substantially involved'' in the project, in which case a cooperative agreement will be used. A common example of substantial involvement is collaboration between NIST scientists and recipient scientists or technicals. Further examples are listed in Section 5.03.d of Department of Commerce Administrative Order 203–26, which can be found at *http://www.osec.doc.gov/bmi/daos/203–26.htm.* NIST will make decisions regarding the use of a cooperative agreement on a case-by-case basis. Funding for contractual arrangements for services and products for delivery to NIST is not available under this announcement.

Additional Requirements

Primary Application Certifications: All primary applicant institutions must submit a completed form CD–511, ''Certifications Regarding Debarment, Suspension and Other Responsibility Matters; Drug-Free Workplace Requirements and Lobbying,'' and the following explanations must be provided:

1. *Nonprocurement Debarment and Suspension.* Prospective participants (as defined at 15 CFR Part 26, Section 105) are subject to 15 CFR Part 26, ''Nonprocurement Debarment and Suspension'' and the related section of the certification form prescribed above applies;

2. *Drug-Free Workplace.* Grantees (as defined at 15 CFR Part 26, Section 605) are subject to 15 CFR Part 26, Subpart F, ''Government wide Requirements for Drug-Free Workplace (Grants)'' and the related section of the certification form prescribed above applies;

3. *Anti-Lobbying.* Persons (as defined at 15 CFR Part 28, Section 105) are subject to the lobbying provisions of 31 U.S.C. 1352, ''Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,'' and the lobbying section of the certification form prescribed above applies to applications/bids for grants, cooperative agreements, and contracts for more than $100,000, and loans and loan guarantees for more than $150,000, or the single family maximum mortgage limit for affected programs, whichever is greater.

4. *Anti-Lobbying Disclosure.* Any applicant institution that has paid or will pay for lobbying using any funds must submit an SF–LLL, ''Disclosure of Lobbying Activities,'' as required under 15 CFR Part 28, Appendix B.

5. *Lower-tier Certifications.* Recipients shall require applicant/bidder institutions for subgrants, contracts, subcontracts, or other lower tier covered transactions at any tier under the award to submit, if applicable, a completed Form CD–512, ''Certifications Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions and Lobbying;'' and disclosure form, SF–LLL, ''Disclosure of Lobbying Activities.'' Form CD–512 is intended for the use of recipients and should not be transmitted to NIST. SF–LLL submitted by any tier recipient or subrecipient should be submitted to NIST in accordance with the instructions contained in the award document.

Name Check Reviews: All for-profit and non-profit applicants will be subject to a name check review process. Name checks are intended to reveal if any key individuals associated with the applicant have been convicted of or are presently facing, criminal charges such as fraud, theft, perjury, or other matters which significantly reflect on the applicant's management honesty or financial integrity. Form CD–346 must be completed for all personnel with key programmatic or fiduciary responsibilities.

Preaward Activities: Applicants (or their institutions) who incur any costs prior to an award being made do so solely at their own risk of not being reimbursed by the Government. Notwithstanding any verbal assurance that may have been provided, there is no obligation on the part of NIST to cover pre-award costs.

No Obligation for Future Funding: If an application is accepted for funding, DOC has no obligation to provide any additional future funding in connection with that award. Renewal of an award to increase funding or extend the period of performance is at the total discretion of NIST.

Past Performance: Unsatisfactory performance under prior Federal awards may result in an application not being considered for funding.

False Statements: A false statement on an application is grounds for denial or termination of funds, and grounds for possible punishment by a fine or imprisonment as provided in 18 U.S.C. 1001.

Delinquent Federal Debts: No award of Federal funds shall be made to an applicant who has an outstanding delinquent Federal debt until either:

1. The delinquent account is paid in full,

2. A negotiated repayment schedule is established and at least one payment is received, or

3. Other arrangements satisfactory to DoC are made.

Indirect Costs: Regardless of any approved indirect cost rate applicable to the award, the maximum dollar amount of allocable indirect costs for which the

DoC will reimburse the Recipient shall be the lesser of:

(a) the Federal Share of the total allocable indirect costs of the award based on the negotiated rate with the cognizant Federal agency as established by audit or negotiation; or

(b) the line item amount for the Federal share of indirect costs contained in the approved budget of the award.

For the *Physics, MSEL, ITL, BFRL, and EEEL SURF Programs,* no Federal funds will be authorized for Indirect Costs (IDC) nor fringe benefits; however, an applicant may provide for IDC and/or fringe benefits under his/her portion of Cost Sharing.

Purchase of American-made Equipment and Products: Applicants are hereby notified that they are encouraged, to the greatest practicable extent, to purchase American-made equipment and products with funding provided under this program.

Federal Policies and Procedures: Recipients and subrecipients under each of the above grant programs shall be subject to all Federal laws and Federal and Departmental regulations, policies, and procedures applicable to financial assistance awards, including 15 CFR Part 14 and 15 CFR Part 24, as applicable.

Each of the above grant programs does not directly affect any state or local government.

Applications under these programs are not subject to Executive Order 12372, ''Intergovernmental Review of Federal Programs.''

Executive Order Statement: This funding notice was determined to be ''not significant'' for purposes of Executive Order 12866.

Dated: January 4, 2001.

Karen H. Brown,

Deputy Director.

[FR Doc. 01–836 Filed 1–10–01; 8:45 am]

BILLING CODE 3510–13–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 010501B]

Pacific 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 Pacific Fishery Management Council's (Council) Highly Migratory Species Plan Development Team (HMSPDT) will hold a work session, which is open to the public.

DATES: The HMSPDT will meet on Monday, February 5, 2001 through Thursday, February 8, 2001, from 8 a.m. to 5 p.m. each day. On Friday, February 9, 2001, the HMSPDT will meet from 8 a.m. until business for the day is completed.

ADDRESSES: The work session will be held in the large conference room at NMFS Southwest Fisheries Science Center, 8604 La Jolla Shores Drive, Room D-203, La Jolla, CA 92038-0271; (619) 546-7000.

Council address: Pacific Fishery Management Council, 2130 SW Fifth Avenue, Suite 224, Portland, OR 97201.

FOR FURTHER INFORMATION CONTACT: Dan Waldeck, Pacific Fishery Management Council; (503) 326-6352.

SUPPLEMENTARY INFORMATION: The primary purpose of the work session is to continue review and revision of the draft fishery management plan (FMP) for highly migratory species (HMS); the draft FMP is scheduled for review by the Council in March 2001.

The proposed FMP and its associated regulatory analyses would be the Council's fourth FMP for the exclusive economic zone off the West Coast. Development of the FMP is timely, considering the new mandates under the Magnuson-Stevens Act, efforts by the United Nations to promote conservation and management of HMS resources through domestic and international programs, and the increased scope of international activities related to HMS fisheries in the eastern Pacific Ocean.

Although non-emergency issues not contained in the HMSPDT meeting agenda may come before the HMSPDT for discussion, those issues may not be the subject of formal HMSPDT action during this meeting. HMSPDT action will be restricted to those issues specifically listed in this document and any issues arising after publication of this document that require emergency action under section 305(c) of the Magnuson-Stevens Act, provided the public has been notified of the HMSPDT's intent to take final action to address the emergency.

Special Accommodations

The meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Ms. Carolyn Porter at (503) 326-6352 at least 5 days prior to the meeting date.

Dated: January 5, 2001.

Richard W. Surdi,

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

[FR Doc. 01–911 Filed 1–10–01; 8:45 am]

BILLING CODE 3510-22-S

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Announcement of Import Restraint Limits for Certain Cotton, Wool and Man-Made Fiber Textile Products Produced or Manufactured in Cambodia

January 8, 2001.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs establishing limits.

EFFECTIVE DATE: January 11, 2001.

FOR FURTHER INFORMATION CONTACT: Roy Unger, 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 Bilateral Textile Agreement of January 20, 1999, between the Governments of the United States and Cambodia establishes limits for the period January 1, 2001 through December 31, 2001.

These limits may be revised if Cambodia becomes a member of the World Trade Organization (WTO) and the United States applies the WTO agreement to Cambodia.

In addition, these limits include a nine percent (9%) increase to all of Cambodia's quotas under the Labor Standards provision of the U.S.-Cambodia bilateral textile agreement (see **Federal Register** notice 64 FR 60428, published on November 5, 1999).

In the letter published below, the Chairman of CITA directs the Commissioner of Customs to establish the 2001 limits.

Carryforward used in the year 2000 is being deducted from the 2001 limits.

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). Information regarding the 2001 CORRELATION will be published in the **Federal Register** at a later date.

Richard B. Steinkamp,

Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

January 8, 2001.

Commissioner of Customs,
Department of the Treasury, Washington, DC 20229.

Dear Commissioner: Pursuant to section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended; and the Bilateral Textile Agreement, dated January 20, 1999, between the Governments of the United States and Cambodia, you are directed to prohibit, effective on January 11, 2001, entry into the United States for consumption and withdrawal from warehouse for consumption of cotton, wool and man-made fiber textile products in the following categories, produced or manufactured in Cambodia and exported during the twelve-month period beginning on January 1, 2001 and extending through December 31, 2001, in excess of the following levels of restraint:

Category	Twelve-month restraint limit
331/631	1,890,086 dozen pairs.
334/634	197,391 dozen.
335/635	79,607 dozen.
338/339	2,902,810 dozen.
340/640	918,543 dozen.
345	115,124 dozen.
347/348/647/648	3,483,372 dozen.
352/652	734,834 dozen.
438	94,618 dozen.
445/446	122,310 dozen.
638/639	1,045,012 dozen.
645/646	306,181 dozen.

The limits set forth above are subject to adjustment pursuant to the provisions of the current bilateral agreement between the Governments of the United States and Cambodia.

Products in the above categories exported during 2000 shall be charged to the applicable category limits for that year (see directive dated December 10, 1999) to the extent of any unfilled balances. In the event the limits established for that period have been exhausted by previous entries, such products shall be charged to the limits set forth in this directive.

These limits may be revised if Cambodia becomes a member of the World Trade Organization (WTO) and the United States applies the WTO agreement to Cambodia.

Moreover, these limits may be revised in light of the U.S. determination as to whether working conditions in the Cambodian textile and apparel sector substantially comply with Cambodian labor law and internationally recognized core labor standards (see **Federal Register** notice 64 FR 60428, published on November 5, 1999).

In carrying out the above directions, the Commissioner of Customs should construe entry into the United States for consumption to include entry for consumption into the Commonwealth of Puerto Rico.

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,

Richard B. Steinkamp,

Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc. 01–1009 Filed 1–9–01; 11:28 am]

BILLING CODE 3510–DR–F

DEPARTMENT OF EDUCATION

National Assessment Governing Board; Meeting

AGENCY: National Assessment Governing Board; Education.

ACTION: Notice of closed teleconference meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of a forthcoming teleconference meeting of the Executive Committee of the National Assessment Governing Board. This notice also describes the functions of the Board. Notice of this meeting is required under Section 10(a)(2) of the Federal Advisory Committee Act.

Date: January 22, 2001.

Time: 4 p.m., adjournment, approximately, 5 p.m. (closed).

Location: National Assessment Governing Board; 800 North Capitol Street, NW., Suite #825, Washington, DC 20001.

FOR FURTHER INFORMATION CONTACT: Ray Fields, Assistant Director for Policy, National Assessment Governing Board, 800 North Capitol Street, NW., Suite 825, Washington, DC 20002–4233, Telephone: (202) 357–6938.

SUPPLEMENTARY INFORMATION: The National Assessment Governing Board is established under section 412 of the National Education Statistics Act of 1994 (Title IV of the Improving America's Schools Act of 1994) (Pub. L. 103–382).

The Board is established to formulate policy guidelines for the National Assessment of Educational Progress. The Board is responsible for selecting subject areas to be assessed, developing assessment objectives, identifying appropriate achievement goals for each grade and subject tested, and establishing standards and procedures for interstate and national comparisons.

Under Pub. L. 105–78, the National Assessment Governing Board is also granted exclusive authority over developing the Voluntary National Tests pursuant to contact number RJ9753001.

On Monday, January 22, the Executive Committee will hold a closed teleconference meeting from 3 to 5 p.m. to review and discuss the qualifications of individuals to fill two vacant National Assessment Governing Board staff positions. Based upon these discussions, the Executive Committee will approve the hire of the individuals selected to fill the position Assistant Director for Psychometrics and the position Operations Officer. This meeting will relate solely to the internal personal rules and practices of an agency and will disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy, and, as such, is protected by exemptions (2) and (6) of Section 552b(c) of Title 5 U.S.C.

A summary of the activities of the closed teleconference, and other related matters which are informative to the public and consistent with the policy of the section 5 U.S.C. 552b(c), will be available to the public within 14 days after the meeting. Records are kept of all Board proceedings and are available for public inspection at the U.S. Department of Education, National Assessment Governing Board, Suite 825, 800 North Capitol Street, NW., Washington, DC, from 8:30 a.m. to 5 p.m.

Roy Truby,

Executive Director, National Assessment Governing Board.

[FR Doc. 01–795 Filed 1–10–01; 8:45 am]

BILLING CODE 4001–01–M

DEPARTMENT OF ENERGY

Office of Science Financial Assistance Program Notice 01–08; Scientific Discovery Through Advanced Computing: Computational Chemistry

AGENCY: U.S. Department of Energy.

ACTION: Notice inviting research grant applications.

SUMMARY: The Office of Basic Energy Sciences of the Office of Science (SC), U.S. Department of Energy (DOE), hereby announces its interest in receiving applications for projects in theory, modeling, and simulation

activities associated with the computational chemistry component of the Scientific Discovery through Advanced Computing (SciDAC) research program. The full text of Program Notice 01–08 is available via the Internet using the following web site address: *http://www.science.doe.gov/production/grants/grants.html.*

DATES: Preapplications referencing Program Notice 01–08, should be received by 4:30 p.m., E.S.T., February 7, 2001. A response encouraging or discouraging the submission of a formal application will be communicated by electronic mail by February 27, 2000. Formal applications in response to this notice should be received by 4:30 p.m., E.S.T., March 15, 2001, to be accepted for merit review and funding in FY 2001.

ADDRESSES: Preapplications referencing Program Notice 01–08 should be sent via e-mail using the following address: sharon.bowser@science.doe.gov.

Formal applications referencing Program Notice 01–08, should be forwarded to: U.S. Department of Energy, Office of Science, Grants and Contracts Division, SC–64, 19901 Germantown Road, Germantown, MD 20874–1290, ATTN: Program Notice 01–08. This address must be used when submitting applications by U.S. Postal Service Express Mail or any commercial mail delivery service, or when hand-carried by the applicant.

FOR FURTHER INFORMATION CONTACT: Dr. William H. Kirchhoff, Office of Science, U.S. Department of Energy, 19901 Germantown Road, Germantown, MD 20874–1290, telephone: (301) 903–5809, E-mail: william.kirchhoff@science.doe.gov, fax: (301) 903–4110.

SUPPLEMENTARY INFORMATION:

Background: Scientific Discovery Through Advanced Computing

Advanced scientific computing will be a key contributor to scientific research in the 21st Century. Within the Office of Science (SC), scientific computing programs and facilities are already essential to progress in many areas of research critical to the nation. Major scientific challenges exist in all SC research programs that can best be addressed through advances in scientific supercomputing, *e.g.*, designing materials with selected properties, elucidating the structure and function of proteins, understanding and controlling plasma turbulence, and designing new particle accelerators. To help ensure its missions are met, SC is bringing together advanced scientific computing and scientific research in an integrated program entitled ''Scientific Discovery Through Advanced Computing.''

The Opportunity and the Challenge

Extraordinary advances in computing technology in the past decade have set the stage for a major advance in scientific computing. Within the next five to ten years, computers 1,000 times faster than today's computers will become available. These advances herald a new era in scientific computing. Using such computers, it will be possible to dramatically extend our exploration of the fundamental processes of nature (*e.g.*, the structure of matter from the most elementary particles to the building blocks of life) as well as advance our ability to predict the behavior of a broad range of complex natural and engineered systems (*e.g.*, the earth's climate or an automobile engine).

To exploit this opportunity, these computing advances must be translated into corresponding increases in the performance of the scientific codes used to model physical, chemical, and biological systems. *This is a daunting problem.* Current advances in computing technology are being driven by market forces in the commercial sector, not by scientific computing. Harnessing commercial computing technology for scientific research poses problems unlike those encountered in previous supercomputers, in magnitude as well as in kind. As noted in the 1998 report [1] from the NSF/DOE ''National Workshop on Advanced Scientific Computing'' and the 1999 report [2] from the President's Information Technology Advisory Committee, this problem will only be solved by increased investments in *computer software*—in research and development on scientific simulation codes as well as on the mathematical and computing systems software that underlie these codes.

Investment Plan of the Office of Science

To meet the challenge posed by the new generation of terascale computers, SC will fund a set of coordinated investments as outlined in its long-range plan for scientific computing, *Scientific Discovery through Advanced Computing* [3] submitted to Congress on March 30, 2000. First, it will create a Scientific Computing Software Infrastructure that bridges the gap between the advanced computing technologies being developed by the computer industry and the scientific research programs sponsored by the Office of Science. Specifically, the SC effort proposes to:

- Create a new generation of Scientific Simulation Codes that take full advantage of the extraordinary computing capabilities of terascale computers.
- Create the Mathematical and Computing Systems Software to enable the Scientific Simulation Codes to effectively and efficiently use terascale computers.
- Create a Collaboratory Software Environment to enable geographically separated scientists to effectively work together as a team and to facilitate remote access to both facilities and data.

These activities are supported by a Scientific Computing Hardware Infrastructure that will be tailored to meet the needs of its research programs. The Hardware Infrastructure is robust, to provide the stable computing resources needed by the scientific applications; agile, to respond to innovative advances in computer technology that impact scientific computing; and flexible, to allow the most appropriate and economical resources to be used to solve each class of problems. Specifically, the SC proposes to support:

- A Flagship Computing Facility, the National Energy Research Scientific Computing Center (NERSC), to provide the robust, high-end computing resources needed by a broad range of scientific research programs.
- Topical Computing Facilities to provide computing resources tailored for specific scientific applications and to serve as the focal point for an application community as it strives to optimize its use of terascale computers.
- Experimental Computing Facilities to assess the promise of new computing technologies being developed by the computer industry for scientific applications.

Both sets of investments will create exciting opportunities for teams of researchers from laboratories and universities to create new revolutionary computing capabilities for scientific discovery.

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[1] This workshop was sponsored by the National Science Foundation and the Department of Energy and hosted by the National Academy of Sciences on July 30–31, 1998. Copies of the report may be obtained from: *http://www.er.doe.gov/production/octr/mics/index.html*

[2] Copies of the PITAC report may be obtained from: *http://www.ccic.gov/ac/report/.*

[3] Copies of the SC computing plan, Scientific Discovery through Advanced Computing, can be downloaded from the SC website at: *http://www.sc.doe.gov/production/octr/index.html.*

Background: Theory, Modeling, and Simulation for Chemistry

This solicitation addresses the Scientific Simulation Codes element of the SciDAC program and in particular, theory, modeling, and simulation for chemistry.

Great progress has been made in the past half century in bringing molecular theory and modeling from a purely qualitative aid to an exact predictive tool for describing the chemical reactions of three and four atom systems, most notably for atoms in the first two rows of the periodic table. Predictive tools for many processes of importance to the Department of Energy's mission such as, but not limited to, combustion and catalysis occur between more complex molecules and between molecules and extended structures such as clusters or surfaces. Moreover, processes such as combustion and catalysis involve a complex interaction of chemistry with fluid dynamics. Predictive modeling of such processes is currently beyond the capabilities of existing computational resources and computational methods.

Applications are solicited for the development of computational approaches to solving problems in the modeling of chemical processes that exceed current computational capabilities. Of particular interest are long-standing problems in computational approaches to predicting chemistry such as:

- Reduction of the power law scaling of current quantum chemistry algorithms for systems with large numbers of atoms and electrons, *i.e.*, alternative approaches to handling the electron correlation problem for many electron systems.
- Calculation with chemical accuracy of the properties of open shell systems such as free radicals and excited electronic states appropriate to many areas of chemistry.
- Calculation of the significant properties of complex systems consisting of hundreds of reactions coupled with fluid dynamics and turbulence.

Advances in computational chemistry in recent years in providing accurate descriptions of increasingly complex systems have come as much from improvements in theory and software as from improved computational hardware. Consequently, applications submitted under this announcement may address fundamental aspects of chemical theory so long as they promise to break through the barriers that currently exist in computational models. That is, while it is anticipated that successful applicants to this announcement will be primarily concerned with taking advantage of the computational resources being developed under SciDAC, it is not necessarily a requirement.

Collaboration

It is expected that all applications submitted in response to this notice will be for collaborative projects, possibly involving more than one institution. Applications submitted from different institutions, which are directed at a common research activity, may include a common technical description of the overall research project. However, each must have a qualified principal investigator, who is responsible for the part of the effort at each institution, and separate face pages and budget pages for each institution. The budget for the proposed work in computer science and applied mathematics should be clearly identified and described, as the Office of Advanced Scientific Computing Research may support this work (up to 20–25% of the total project cost). In addition, if the distinct scope of work proposed for each institution is not specified in the common technical description, it must be clearly stated in the individual applications. Applicants should include cost sharing whenever feasible. Collaborations with researchers in federal laboratories and Federally Funded Research and Development Centers (FFRDCs), including the DOE National Laboratories are encouraged.

Since each project will be developing new computational tools and physics models that could be useful in other projects, it is important that there be good communication between the different projects. Greater collaboration than usual is anticipated to be required for the research projects likely to be funded under this notice. The investigators involved should anticipate regularly scheduled meetings, not to exceed three per year, during the start up of the SciDAC program in order to assure the necessary coordination of efforts between physical scientists, mathematicians, and computer scientists.

Program Funding

It is anticipated that up to $1 million annually will be available for multiple awards for research in the areas described in this notice. Initial awards will be made in FY 2001 in the categories described above, and applications may request project support for up to three years. All awards are contingent on the availability of funds, research progress, and programmatic needs. Annual budgets for successful, individual projects submitted under this notice are expected to range from $100,000 to $500,000 per project in FY 2001, depending on the number of investigators and institutions involved. Annual budgets may increase in subsequent years but will be subject to the overall annual maximum guidance and availability of funds. Any proposed effort that exceeds the annual maximum ($1 million) in the subsequent years should be separately identified for potential award increases if additional funds become available.

As required by the SC Grant Application Guide, applicants must submit their budgets using the Budget Page (DOE Form 4620.1) with one Budget Page for each year of requested funding. The requested funding for the proposed work in computer science and applied mathematics should be included with the other projects costs on the Budget Page. However, applicants are also requested to list the proposed computer science and applied mathematics costs separately in an appendix, as the Office of Advanced Scientific Computing Research may support this work (up to 20–25% of the total project cost).

Preapplications

Preapplications are strongly encouraged but not required prior to submission of a full application. However, notification of a successful preapplication is not an indication that an award will be made in response to the formal application. The preapplication should identify on the cover sheet the institution, Principal Investigator name(s), address(s), telephone, and fax number(s) and E-mail address(es), title of the project, and the field of scientific research. A brief (one-page) vitae should be provided for each Principal Investigator. The preapplication should consist of a two to three page narrative describing the research project objectives, the approach to be taken, and a description of any research partnerships. Preapplications will be reviewed by DOE relative to the scope and research needs of the computational chemistry program.

Merit Review

Applications will be subjected to scientific merit review (peer review) and will be evaluated against the following evaluation criteria listed in descending order of importance as codified at 10 CFR 605.10(d):

1. Scientific and/or Technical Merit of the Project,

2. Appropriateness of the Proposed Method or Approach,

3. Competency of Applicant's Personnel and Adequacy of Proposed Resources,

4. Reasonableness and Appropriateness of the Proposed Budget.

The evaluation under item 2, Appropriateness of the Proposed Method or Approach, will also consider the quality of the plan for effective coupling to emerging advances in supercomputing.

Note that external peer reviewers are selected with regard to both their scientific expertise and the absence of conflict-of-interest issues. Non-federal reviewers may be used, and submission of an application constitutes agreement that this is acceptable to the investigator(s) and the submitting institution. Reviewers will be selected to represent expertise in the technology areas proposed, applications groups that are potential users of the technology, and related programs in other Federal Agencies or parts of DOE such as the Advanced Strategic Computing Initiative (ASCI) within DOE's National Nuclear Security Administration.

Information about the development and submission of applications, eligibility, limitations, evaluation, selection process, and other policies and procedures including detailed procedures for submitting applications from multi-institution partnerships may be found in 10 CFR Part 605, and in the Application Guide for the Office of Science Financial Assistance Program. Electronic access to the Guide and required forms is made available via the World Wide Web at: *http://www.science.doe.gov/production/grants/grants.html.* The Project Description must be 20 pages or less, including tables and figures, but exclusive of attachments. The application must contain an abstract or project summary, letters of intent from collaborators, and short vitae.

(The Catalog of Federal Domestic Assistance Number for this program is 81.049, and the solicitation control number is ERFAP 10 CFR Part 605.)

Issued in Washington, DC on January 4, 2001.

Ralph H. De Lorenzo,

Acting Associate Director of Science for Resource Management.

[FR Doc. 01–837 Filed 1–10–01; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP98–100–001]

Algonquin Gas Transmission Company; Notice of Application

January 5, 2001.

Take notice that on December 20, 2000, Algonquin Gas Transmission Company (Algonquin) filed an abbreviated application in Docket No. CP98–100–001 to amend its Certificate of Public Convenience and Necessity, pursuant to section 7 of the Natural Gas Act and Part 157 of the Federal Energy Regulatory Commission's Regulations, issued to Algonquin by the Commission's May 27, 1998 ''Order Issuing Certificate'' in Docket No. CP98–100–000, as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may be viewed via the internet at *http://www.ferc.fed.us/online/rims,htm* (call 202–208–2222 for assistance). Any questions regarding the application should be directed to S.E. Tillman, Director of Regulatory Affairs, Algonquin Gas Transmission Company, P.O. Box 1642, Houston, Texas 77251–1642 at (713) 627–5113.

The May 27 Order authorized Algonquin to construct and operate pipeline facilities to provide transportation service to ANP Bellingham Energy Company. In this application, Algonquin requests all authorizations necessary to amend its certificate to revise the initial monthly demand rate under Rate Schedule AFT–CL from $.8399 per Dth to $.9714 per Dth to reflect increased costs associated with construction of the lateral project. Algonquin submits that the increase in estimated costs of approximately $700,000 is a result of: (1) Higher contractor costs; (2) higher right-of-way costs; and (3) increased AFUDC due to attenuation of the construction schedule. In addition, Algonquin provides that since the costs of the proposed facilities will be recovered through an incremental reservation charge, the amendment will have no adverse impact on existing customers.

The application also provides that ANP Bellingham has authorized Algonquin to state that ANP Bellingham agrees to pay such revised rate and does not oppose Algonquin filing to modify the original approved initial rate.

Algonquin provides that no other changes are contemplated with regard to the facilities authorized in Docket No. CP98–100–000, nor in the service to be provided for the proposed receipt or delivery point.

Any person desiring to be hear or to make any protest with reference to said application should on or before January 18, 2001, file with the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426, a motion to intervene or protest in accordance with the requirements of the Commission's Rules of Practice and procedure (18 CFR 385.211 and 385.214) and the regulations under the NGA (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party in any proceeding must file a petition to intervene in accordance with the Commission's rules. Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Commission by sections 7 and 15 of the NGA and the Commission's Rules of Practice and procedure, a hearing will be held without further notice before the Commission or its designee on this application if no petition to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that the proposal is required by the public convenience and necessity. If a petition for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given. Under the procedure provide for, unless otherwise advised, it will be unnecessary for the Applicants to appear or to be represented at the hearing.

David P. Boergers,

Secretary.

[FR Doc. 01–866 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP00–325–001]

Colorado Interstate Gas Company; Notice of Tariff Filing

January 5, 2001.

Take notice that on January 2, 2001, Colorado Interstate Gas Company (CIG), tendered for filing to become part of its FERC Gas Tariff, First Revised Volume No. 1, the pro forma tariff sheets filed pursuant to Order No. 637 and which are listed in Appendix A to the filing.

CIG states these tariff sheets reflect the changes to its tariff required to comply with Order No. 637, 637–A and 637–B (Order).

CIG further states that the pro forma tariff sheets filed in this filing reflect changes from its originally filed pro forma tariff sheets filed June 15, 2000, which CIG agreed to in a September 20, 2000 response to interventions and during technical conferences.

CIG further states that copies of this filing have been served on all parties in this proceeding.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with section 385.211 of the Commission's Rules and Regulations. All such protests must be filed on or before January 22, 2001. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–851 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP96–389–017]

Columbia Gulf Transmission Company; Notice of Negotiated Rate Filing

January 5, 2001.

Take notice that on December 29, 2000, Columbia Gulf Transmission Company (Columbia Gulf) tendered for filing to the Federal Energy Regulatory Commission (Commission) the following Amendment Agreement to a recently filed negotiated rate transaction:

Amendment Agreement to ITS–2 Service Agreement No. 69314 between Columbia Gulf Transmission Company and Amoco Energy Trading Corporation dated November 30, 2000, as Amended December 22, 2000.

Columbia Gulf states that transportation service which was scheduled to commence December 1, 2000 and terminate December 31, 2000. The parties have executed an Amendment Agreement extending the term through January 31, 2001. All other terms and provisions remain unchanged and in full force and effect.

Columbia Gulf states that copies of the filing have been served on all parties on the official service list created by the Secretary in this proceeding.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *hittp://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–857 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. MG00–6–002, 003 and 004, EC99–81–003 and 004, MT00–17–000]

Dominion Resources, Inc. and Dominion Transmission Inc. (Formerly CNG Transmission Inc.); Notice of Meeting

January 5, 2001.

This is to inform all parties in the proceedings that on January 12, 2001, Dominion senior officials will meet with staff to discuss compliance with the Commission's orders in these dockets. The meeting will be held at 1 p.m. in Room 3M–1 at the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426. All interested parties are permitted to attend.

David P. Boergers,

Secretary.

[FR Doc. 01–867 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP00–555–002]

Dominion Transmission, Inc.; Notice of Compliance Filing

January 5, 2001.

Take notice that on January 2, 2001, Dominion Transmission, Inc. (DTI) tendered for filing as part of its FERC Gas Tariff, Third Revised Volume No. 1, the following tariff sheet, with an effective date of September 23, 2000.

Substitute Original Sheet No. 1092.

DTI states that the filing is made as a compliance filing pursuant to the Commission's December 15, 2000 order in the captioned proceedings. 93 FERC ¶61,284 (2000). As directed by the Commission, DTI has stated in its tariff that information regarding its shared personnel and facilities is available on its website. In addition, DTI included a ministerial change, updating phone numbers in a related complaint procedures tariff provision. DTI

proposes an effective date of September 23, 2000, for the filed tariff sheet to coincide with the effective date of the remainder of its original Third Revised Volume No. 1.

DTI states that copies of its filing have been served upon DTI's customers and interested state commissions.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance).

Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi /doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–850 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP96–383–018]

Dominion Transmission, Inc.; Notice of Filing

January 5, 2001.

Take notice that on December 29, 2000, Dominion Transmission, Inc. (DTI) submitted tariff sheets disclosing recently negotiated rate transactions. The tariff sheets relate to future negotiated rate transactions between DTI and ''Poor Operators.'' DTI and the Pool Operators will enter into Service Agreements under DTI's Rate Schedule IT, to become effective January 1, 2001. Under these agreements, DTI has agreed to provide certain interruptible transportation service for the Pool Operators, for delivery at Dominion's Appalachian Aggregation Points.

DTI states that copies of its letter of transmittal and enclosures have been served upon DTI's customers and interested state commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–858 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. GT01–6–000]

Koch Gateway Pipeline Company and Gulf South Pipeline Company, LP; Notice of Tariff Filing

January 5, 2001.

Take notice that on December 22, 2000, Koch Gateway Pipeline Company and Gulf South Pipeline Company, LP tendered for filing as part of its FERC Gas Tariff, Sixth Revised Volume No. 1 to reflect a corporate name change to become effective December 31, 2000.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with section 385.211 of the Commission's Rules and Regulations. All such protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–864 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP99–322–004]

Northern Border Pipeline Company; Notice of Compliance Tariff Filing

January 5, 2001.

Take notice that on December 29, 2000, Northern Border Pipeline Company (Northern Border) tendered for filing to become part of Northern Border Pipeline Company's FERC Gas Tariff, First Revised Volume No. 1, the tariff sheets listed on Appendix A to the filing, with the effective date as shown on Appendix A.

On September 26, 2000, Northern Border filed a Stipulation and Agreement (Stipulation) in Northern Border's rate case proceeding at Docket No. RP99–322–000, *et al.* In an order dated December 13, 2000 (93 FERC ¶ 61,261), the Commission approved the Stipulation. As provided for in Article VIII.A. of the Stipulation, Northern Border is filing compliance tariff sheets that are necessary after the issuance of the Commission's Order approving the Stipulation to conform the tariff revisions shown in Appendix C of the Stipulation with tariff revisions that were approved by the Commission in order separate proceedings that took place after the submission of the Stipulation, and to reflect the appropriate revision numbers and effective dates for the tariff sheets resulting from this proceeding into Northern Border's effective FERC Gas Tariff, First Revised Volume No. 1.

Northern Border states that it has served a copy of this filing upon all parties of record in this proceeding.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the

Federal Energy Regulatory Commission, 888 first Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be reviewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–852 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP96–272–024]

Northern Natural Gas Company; Notice of Proposed Changes in FERC Gas Tariff

January 5, 2001.

Take notice that on December 29, 2000, Northern Natural Gas Company (Northern) tendered for filing to become part of Northern's FERC Gas Tariff, Fifth Revised Volume No. 1, the following tariff sheets, proposed to become effective on January 1, 2001:

Fourteenth Revised Sheet No. 66
Fifth Revised Sheet No. 66A
Second Revised Sheet No. 66B

Northern states that the above sheets are being filed to implement specific negotiated rate transactions with OGE Energy Resources, Inc., Oneok Energy Marketing and Trading Company, and Aquila Energy Marketing Corporation in accordance with the Commission's Policy Statement on Alternatives to Traditional Cost-of-Service Ratemaking for Natural Gas Pipelines. In addition, those negotiated rates that have expired have been deleted.

Northern further states that copies of the filing have been mailed to each of its customers and interested State Commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–860 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP01–34–002]

Overthrust Pipeline Company; Notice of Compliance Filing

January 5, 2001.

Take notice that on December 7, 2000, Overthrust Pipeline Company (Overthrust) tendered its answer to protest.

Overthrust states that the purpose of this filing is to comply with Ordering Paragraph (C) of the Commission's Order on filings to establish Imbalance Netting and Trading Pursuant to Order Nos. 587–G and 587–L issued November 9, 2000, in Docket Nos. RM96–1–014, *et al.,* which directed Overthrust to file an answer to the joint protest of protestors in Docket No. RP01–34–000.

Overthrust states that a copy of this answer has been served upon each person designated of the official service list compiled by the Secretary in this proceeding.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed by January 12, 2001. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–848 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP96–200–065]

Reliant Energy Gas Transmission Company; Notice of Proposed changes in FERC Gas Tariff

January 5, 2001.

Take notice that on December 29, 2000, Reliant Energy Gas Transmission Company (REGT) tendered for filing as part of its FERC Gas Tariff, Fifth Revised Volume No. 1, the following tariff sheet to be effective January 1, 2001:

Original Sheet No. 8M

REGT states that the purpose of this filing is to reflect the addition of a new negotiated rate contract.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the

Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–861 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP96–200–064]

Reliant Energy Gas Transmission Company; Notice of Proposed Changes in FERC Gas Tariff

January 5, 2001.

Take notice that on December 29, 2000, Reliant Energy Gas Transmission Company (REGT) tendered for filing as part of its FERC Gas Tariff, Fifth Revised Volume No. 1, the following tariff sheet to be effective January 1, 2001:

Fifth Revised Sheet No. 8L

REGT states that the purpose of this filing is to reflect the addition of one new negotiated rate contract.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This Filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. Sec, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–862 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP01–199–000]

Sea Robin Pipleline Company; Notice of Flowthrough Crediting Report

January 5, 2001.

Take notice that on December 21, 2000, Sea Robin Pipeline Company (Sea Robin) submitted its Annual Flowthrough Crediting Mechanism Filing. Sea Robin states that this filing was made pursuant to section 27 of the General Terms and Conditions of Sea Robin's FERC Gas Tariff which requires the crediting of certain amounts received as a result of resolving monthly imbalances between its gas and liquefiables shippers and under its operational balancing agreements, and imposing scheduling penalties during the 12 month period ending October 31, 2000.

Sea Robin reports that it paid $373,679.45 in excess of amounts received from shippers. In accordance with section 27.1, the excess amount paid by Sea Robin will be carried forward and offset against any accumulated amounts during the subsequent twelve-month period.

Sea Robin further states that a copy of this filing is available for public inspection during regular business hours at Sea Robin's office at 5444 Westheimer Road, Houston, Texas 77056–5306. In addition, copies of this filing are being served on all affected customers, applicable state regulatory agencies and parties to the proceeding.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with section 385.211 of the Commission's Rules and Regulations. All such protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.fed.us/online/rims.htm* (call 202–208–2222 for assistance).

Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–847 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. RP96–312–037 and GT01–5–001]

Tennessee Gas Pipeline Company; Notice of Compliance Filing

January 5, 2001.

Take notice that on December 19, 2000, Tennessee Gas Pipeline Company (''Tennessee''), P.O. Box 2511, Houston, Texas 77252, tendered for filing (1) Substitute Original Sheet No. 30G and First Revised Sheet No. 413A for inclusion in Tennessee's FERC Gas Tariff, Fifth Revised Volume No. 1, and (2) a copy of a July 31, 2000 Gas Transportation Agreement between Tennessee and Milford Power Company (the ''Milford Agreement'').

Tennessee states that the Milford Agreement and First Revised Sheet No. 413A are being filed in compliance with the Commission's December 13, 2000 letter order (''December 13 Order'') in the above-referenced proceeding. In that regard, in its December 13 Order, the Commission found the Milford Agreement to be a non-conforming service agreement. In addition, Tennessee has revised Original Tariff Sheet No. 30G to indicate that the Milford Agreement deviates in a material respect from Tennessee's pro forma Rate Schedule FT–A Gas Transportation Agreement Tennessee requests that the Commission approve the Milford Agreement and First Revised Sheet No. 413A affective January 18, 2001 and Substitute Original Sheet No. 30G effective December 15, 2000.

Tennessee states that copies of the filing have been mailed to all affected customers and state regulatory commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission,

888 First Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–859 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP97–255–020]

TransColorado Gas Transmission Company; Notice of Tariff Filing

January 5, 2001.

Take notice that on January 3, 2001, TransColorado Gas Transmission Company (TransColorado) tendered for filing as part of its FERC Gas Tariff, Original Volume No. 1, Twentieth Revised Sheet No. 21 and Sixteenth Revised Sheet No. 22, with an effective date of January 3, 2001.

TransColorado states that the filing is being made in compliance with the Commission's letter order issued March 20, 1997, in Docket No. RP97–255–000, to be effective January 3, 2001.

TransColorado states that the tendered tariff sheets revised TransColorado's Tariff to reflect the negotiated-rate contract with Enserco Energy, Inc.

TransColorado stated that a copy of this filing has been served upon all parties to this proceeding, TransColorado's customers, the Colorado Public Utilities Commission and the New Mexico Public Utilities Commission.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with Section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–854 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP97–255–018]

TransColorado Gas Transmission Company; Notice of Tariff Filing

January 5, 2001.

Take notice that on December 28, 2000, pursuant to 18 CFR 154.7 and 154.203, and in compliance with the Commission's letter order issued March 20, 1997, in Docket No. RP97–255–000, TransColorado Gas Transmission Company (TransColorado) tendered for filing and acceptance, to be effective January 1, 2001, Eighteenth Revised Sheet No. 21 and Fourteenth Revised Sheet No. 22 to Original Volume No. 1 of its FERC Gas Tariff.

The tendered tariff sheets revised TransColorado's Tariff to reflect the amended negotiated-rate contract with Retex, Inc. as well as the deletion of expired contracts. TransColorado requested waiver of 18 CFR 154.207 so that the tendered tariff sheets may become effective January 1, 2001.

TransColorado stated that a copy of this filing has been served upon all parties to this proceeding, TransColorado's customers, the Colorado Public Utilities Commission and the New Mexico Public Utilities Commission.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–855 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP97–255–019]

TransColorado Gas Transmission Company; Notice of Tariff Filing

January 5, 2001.

Take notice that on January 2, 2001, TransColorado Gas Transmission Company (TransColorado) tendered for filing as part of its FERC Gas Tariff, Original Volume No. 1, Nineteenth Revised Sheet No. 21 and Fifteenth Revised Sheet No. 22, to become effective January 2, 2001.

TransColorado states that the filing is being made in compliance with the Commission's letter order issued March 20, 1997, in Docket No. RP97–255–000.

TransColorado states that the tendered tariff sheets revised TransColorado's Tariff to reflect the negotiated-rate contract with Texaco Natural Gas Inc.

TransColorado stated that a copy of this filing has been served upon all parties to this proceeding, TransColorado's customers, the

Colorado Public Utilities Commission and the New Mexico Public Utilities Commission.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at 0000*http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–856 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. TM99–6–29–004]

Transcontinental Gas Pipe Line Corporation; Notice of Compliance Filing

January 5, 2001.

Take notice that on December 29, 2000, Transcontinental Gas Pipe Line Corporation (Transco) tendered for filing the calculation of the appropriate refund amount with interest and the supporting workpapers in Docket No. TM99–6–29–001. Transco also tendered for filing pro forma tariff sheets to its FERC Gas Tariff, Third Revised Volume No. 1 reflecting revised fuel retention percentages for the annual period commencing April 1, 2000. The proposed effective date of such tariff sheets is April 1, 2000.

Transco states that the instant filing is submitted in compliance with the Commission's Notice of Extension of Time issued November 30, 2000 in Docket No. TM99–6–29–001. In that notice, the Commission granted Transco an extension of time to file its refund calculation and justification of the appropriate refunds with interest as specified by the Commission's October 30, 2000 ''Order on Rehearing''.

Transco states that it is serving copies of the instant filing to its affected customers and interested State Commissions.

Any person desiring to protest said filing should file a protest with the Federal Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed on or before January 12, 2001. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–845 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP97–288–008]

Transwestern Pipeline Company; Notice of Proposed Changes in FERC Gas Tariff

January 5, 2001.

Take notice that on December 29, 2000, Transwestern Pipeline Company (Transwestern) tendered for filing to become part of Transwestern's FERC Gas Tariff, Second Revised Volume No. 1, the following tariff sheets, proposed to become effective on January 1, 2001.

Fifth Revised Sheet No. 5B.05
Fourth Revised Sheet No. 5B.07

Transwestern states that the above sheets are being filed to describe a negotiated rate agreement with Reliant Energy Services, Inc. in accordance with the Commission's Policy Statement on Alternatives to Traditional Cost-of-Service Ratemaking for Natural Gas Pipelines.

Transwestern further states that copies of the filing have been mailed to each of its customers and interested State Commissions.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–853 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP00–595–001]

Viking Gas Transmission Company; Notice of Compliance Filing

January 5, 2001.

Take notice that on January 2, 2001, Viking Gas Transmission Company (Viking) filed a statement of its compliance with section 284.12(c)(3)(i)(B) of the Commission's regulations, 18 CFR 284.12(c)(3)(i)(B), in accordance with the Commission's October 3, 2000 Letter Order issued in Docket Nos. RM96–1–009 and RP00–595–000.

Any person desiring to protest said filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be

filed on or before January 12, 2001. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–849 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP01–60–000]

Williams Gas Pipelines Central, Inc.; Notice of Request Under Blanket Authorization

January 5, 2001.

Take notice that on December 28, 2000, Williams Gas Pipelines Central, Inc. (Williams), P.O. Box 20008, Owensboro, Kentucky 42304, filed in Docket No. CP01–60–000 a request pursuant to sections 157.205 and 157.211 of the Commission's Regulations (18 CFR 157.205 and 157.211) under the Natural Gas Act (NGA) for authorization to construct and operate delivery point facilities for service to a residential end-user in Johnson County, Kansas, under Williams' blanket certificate issued in Docket No. CP82–479–000, pursuant to section 7 of the NGA, all as more fully set forth in the application which is on file with the Commission and open to public inspection. This filing may be viewed on the web at *http://www.ferc.fed.us/online/htm* (call 202–208–2000 for assistance).

Williams requests authorization to construct and operate delivery point facilities to serve Mr. Dennis M. Langley, who requires the gas for residential heating and cooling use. It is stated that Williams will use the facilities to transport up to 20 Dt equivalent of natural gas per day on a firm basis for a 10-year term, pursuant to section 284.223 of the Commission's regulations. It is stated further that Mr. Langley may also receive additional volumes on an interruptible basis. Williams estimates the cost of the facilities at $25,664 and states that it would be reimbursed for the cost by Mr. Langley. It is explained that Mr. Langley's natural gas requirements are currently being supplied by Kansas Gas Service, Inc., a local distribution company that is an existing customer of Williams. It is asserted that Williams has sufficient capacity to render the proposed service without detriment or disadvantage to its other existing customers and that Williams' tariff does not prohibit the addition of delivery point facilities. It is further asserted that the proposal will have no significant impact on Williams' peak day and annual deliveries.

Any questions regarding the application may be directed to David N. Roberts, Manager of Certificates and Tariffs, at (270) 688–6712, Williams Gas Pipelines Central, Inc., P.O. Box 20008, Owensboro, Kentucky 42304.

Any person or the Commission's staff may, within 45 days after issuance of the instant notice by the Commission, file pursuant to Rule 214 of the Commission's Procedural Rules (18 CFR 385.214) a motion to intervene or notice of intervention and pursuant to section 157.205 of the Regulations under the NGA (18 CFR 157.205) a protest to the request. Comments and protests may be filed electronically in lieu of paper. See 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's website at *http://ferc.fed.us/efi/doorbell.htm*. If no protest is file within the time allowed therefor, the proposed activity shall be deemed to be authorized effective the day after the time allowed for filing a protest. If a protest is filed and not withdrawn within 30 days after the time allowed for filing a protest, the instant request shall be treated as an application for authorization pursuant to section 7 of the NGA.

David P. Boergers,

Secretary.

[FR Doc. 01–865 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP01–204–000]

Williston Basin Interstate Pipeline Company; Notice of Fuel Reimbursement Charge Filing

January 5, 2001.

Take notice that on December 29, 2000, Williston Basin Interstate Pipeline Company (Williston Basin), tendered for filing as part of its FERC Gas Tariff, Second Revised Volume No. 1 and Original Volume No. 2 the following revised tariff sheets, to become effective February 1, 2001:

Second Revised Volume No. 1

Fortieth Revised Sheet No. 15
Twenty-first Revised Sheet No. 15A
Forty-second Revised Sheet No. 16
Twenty-first Revised Sheet No. 16A
Thirty-ninth Revised Sheet No. 18
Twenty-first Revised Sheet No. 18A
Twenty-first Revised Sheet No. 19
Twenty-first Revised Sheet No. 20
Thirty-fifth Revised Sheet No. 21

Original Volume No. 2

Eight-fourth Revised Sheet No. 11B

Williston Basin states that the revised tariff sheets reflect revisions to the fuel reimbursement charge and percentage components of the Company's relevant gathering, transportation and storage rates, pursuant to Williston Basin's Fuel Reimbursement Adjustment Provision contained in section 38 of the General Terms and Conditions of its FERC Gas Tariff, Second Revised Volume No. 1.

Any person desiring to be heard or to protest said filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Sections 385.214 or 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed in accordance with section 154.210 of the Commission's Regulations. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceedings. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room. This filing may be viewed on the web at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance). Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.200(a)(1)(iii) and the instructions on

the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

David P. Boergers,

Secretary.

[FR Doc. 01–846 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER01–424–001, et al.]

Pacific Gas and Electric Company, et al.; Electric Rate and Corporate Regulation Filings

January 4, 2001.

Take notice that the following filings have been made with the Commission:

1. Pacific Gas and Electric Company

[Docket No. ER01–424–001]

Take notice that on December 26, 2000, Pacific Gas and Electric Company (PG&E), tendered a filing to pass-through certain charges in conformance with the California Independent System Operator Corporation's December 15, 2000 informational filing in FERC Docket No. ER01–313–001.

PG&E requests an effective date of January 1, 2001, or the date the Commission makes effective ISO rates included in the ISO's informational filing of December 15, 2000.

Copies of this filing have been served upon the California Public Utilities Commission, all affected customers and the official service list in FERC Docket No. ER01–424–000.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

2. Constellation Energy Group, Inc., Constellation Enterprises, Inc. (On Behalf of Themselves and Their Public Utility Subsidiaries), Constellation Power Source, LLC, Constellation Power Source Generation, LLC, and Calvert Cliffs Nuclear Power Plant, LLC

[Docket Nos. EC01–50–000 and ER01–824–000]

Take notice that on December 28, 2000, Constellation Energy Group, Inc. (CEG) and Constellation Enterprises, Inc., on behalf of themselves and their public utility subsidiaries, (jointly the Applicants) submitted for filing, pursuant to Section 203 of the Federal Power Act (FPA) and Part 33 of the Commission's regulations, an Application for authorization to transfer certain jurisdictional transmission facilities as part of transactions involving an intra corporate realignment, purchase by an affiliate of The Goldman Sachs Group, Inc. of an indirect ownership interest in certain jurisdictional public utilities to be owned by a to-be-formed entity, and the distribution by CEG of its shares in the new entity to the public shareholders of CEG. In addition, pursuant to Section 205 of the FPA and 18 CFR 35.16, Constellation Power Source, LLC, Constellation Power Source Generation, LLC and Calvert Cliffs Nuclear Power Plant, LLC have filed notices of succession with the Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

3. Xcel Energy Services Inc.

[Docket No. EC01–51–000]

Take notice that on December 29, 2000, Xcel Energy Services Inc. (Xcel Services) submitted an application pursuant to section 203 of the Federal Power Act and Part 33 of the regulations of the Federal Energy Regulatory Commission (Commission) to effect certain transactions incident to the transfer by Southwestern Public Service Company (SPS) of certain jurisdictional facilities. Xcel Services submitted the application on behalf of SPS and the affiliates of SPS that will be formed to effect the transfer of jurisdictional facilities that is the subject of the application. Xcel Services states that the transfer of jurisdictional facilities is necessary to separate the corporate ownership of SPS' generation and power marketing business from the corporate ownership of SPS' transmission and distribution business as required by retail choice laws in the states of Texas and New Mexico.

Comment date: January 19, 2001, in accordance with Standard Paragraph E at the end of this notice.

4. Mountain View Power Partners, LLC

[Docket No. EG01–93–000]

Take notice that on December 29, 2000, Mountain View Power Partners, LLC (Mountain View), whose sole member is currently SeaWest WindPower, Inc., located at 1455 Frazee Road, San Diego, California, 92108, filed with the Federal Energy Regulatory Commission an application for determination of exempt wholesale generator status pursuant to Part 365 of the Commission's regulations.

Mountain View will construct, own or lease and operate a wind-powered generating facility of approximately 44.4 MW capacity in the San Gorgonio Pass of Riverside County, California, near the City of Palm Springs. The proposed wind power plant is expected to deliver test power to the grid no later than February 15, 2001 and to commence commercial operations by May 1, 2001.

Comment date: January 25, 2001, in accordance with Standard Paragraph E at the end of this notice. The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application.

5. Disropi, S.A.

[Docket No. EG01–94–000]

Take notice that on December 29, 2000 Disropi, S.A., a corporation (sociedad anonima) organized under the laws of Costa Rica (Applicant)1, with its principal place of business at c/o Energia Global de Costa Rica S.A., Parque Empresa Forum, Piso 1, Edificio B, Condominio No. 1, Santa Ana, Costa Rica, filed with the Federal Energy Regulatory Commission an application for determination of exempt wholesale generator status pursuant to Part 365 of the Commission's regulations.

Applicant operates an approximately 20 megawatt (net), wind powered electric power production facility located in north central Costa Rica.

Comment date: January 25, 2001, in accordance with Standard Paragraph E at the end of this notice. The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application.

6. FirstEnergy Generation Corp.

[Docket No. EG01–95–000]

Take notice that on December 29, 2000, FirstEnergy Generation Corp. submitted an application for determination of exempt wholesale generator status pursuant to Section 32 of the Public Utility Holding Company Act of 1935 and Part 365 of the Commission's regulations.

The applicant states that it is a wholly-owned subsidiary of FirstEnergy Services Corp., and that it was created to implement a state-mandated restructuring plan that requires the corporate separation of FirstEnergy Corp.'s competitive generation activities from its transmission and distribution activities. The applicant states further that it will operate the facilities identified in the filing for the purposes of producing and selling power at wholesale.

Comment date: January 25, 2001, in accordance with Standard Paragraph E at the end of this notice. The Commission will limit its consideration of comments to those that concern the adequacy or accuracy of the application.

7. Wolverine Power Supply Cooperative, Inc.

[Docket No. ES01–14–000]

Take notice that on December 22, 2000, Wolverine Power Supply Cooperative, Inc. (Wolverine) submitted an application seeking authorization to execute a guarantee of debt in an amount not to exceed $500,000 incurred by Wolverine Power Marketing Cooperative, Inc., a distribution cooperative member of Wolverine.

Wolverine also seeks a waiver of the Commission's competitive bidding and negotiated placement requirements at 18 CFR 34.2.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

8. Entergy Services, Inc., On behalf of the Entergy Operating Companies: Entergy Arkansas, Inc., Entergy Gulf States, Inc., Entergy Louisiana, Inc., Entergy Mississippi, Inc., and Entergy New Orleans, Inc.

[Docket No. RT01–75–001]

Take notice that on December 29, 2000, Entergy Services, Inc., on behalf of the Entergy Operating Companies, Entergy Arkansas, Inc., Entergy Gulf States, Inc., Entergy Louisiana, Inc., Entergy Mississippi, Inc., and Entergy New Orleans, Inc. (collectively Entergy), filed an Application for approval of Transco's rate structure pursuant to Section 205 of the Federal Power Act and Order No. 2000.

Entergy will create Transco, an independent, incentive-driven transmission company to operate under the oversight, and within the umbrella, of the Southwest Power Pool Regional Transmission Organization. Entergy also submitted for filing a Transmission Cost Transition Agreement, an Open Access Distribution Service Tariff and a Notice of Cancellation for the MSS–2 service schedule of the Entergy System Agreement.

Comment date: January 29, 2001, in accordance with Standard Paragraph E at the end of this notice.

9. Pacific Gas and Electric Company

[Docket No. ER01–783–000]

Take notice that on December 26, 2000, Pacific Gas and Electric Company (PG&E), tendered for filing a changes in rates for the Transmission Revenue Balancing Account Adjustment (TRBAA) rate set forth in its Transmission Owner Tariff (TO Tariff) and for the Reliability Services (RS) rates set forth in both its TO Tariff and its Reliability Services Tariff (RS Tariff) (certain customers' RS rates are in the TO Tariff while other customers' RS rates are in the separate RS Tariff). The TO Tariff TRBAA rate is proposed to be a negative $0.00157 per kilowatt-hour, a reduction from the present rate of negative $0.00017 per kilowatt-hour and the proposed overall average RS rates are approximately 23% lower than the currently effective rates for 2000. These changes in rates are to become effective January 1, 2001.

Copies of this filing have been served upon the California Independent System Operator, California Independent System Operator-registered Scheduling Coordinators, Southern California Edison Company, San Diego Gas and Electric Company, the California Public Utilities Commission and those parties to the official service lists in FERC Docket Nos. ER99–4323–000 and ER01–66–000.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

10. Avista Corp.

[Docket No. ER01–784–000]

Take notice that on November 26, 2000, Avista Corp. (AVA), tendered for filing with the Federal Energy Regulatory Commission executed Service Agreements for Short-Term Firm and Non-Firm Point-To-Point Transmission Service under AVA's Open Access Transmission Tariff—FERC Electric Tariff, Volume No. 8 with El Paso Merchant Energy, L. P.

AVA requests the Service Agreements be given a respective effective date of December 19, 2000.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

11. Cinergy Services, Inc.

[Docket No. ER01–785–000]

Take notice that on December 26, 2000, Cinergy Services, Inc. (Cinergy), tendered for filing a Network Service Agreement, Network Operating Agreement, and Specifications for Network Integration Service under Cinergy's Open Access Transmission Tariff (OATT) entered into between Cinergy and The Village of Blanchester.

An application for Network Integration Service for The Village of Blanchester, Ohio has been included as an Exhibit to the Service Agreement under OATT.

Copies of the filing were served upon The Village of Blanchester, Ohio.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

12. Florida Power Corporation

[Docket No. ER01–786–000]

Take notice that on December 26, 2000, Florida Power Corporation (Florida Power), tendered for filing an executed Interconnection and Operating Agreement (Interconnection Agreement) with Vandolah Power Company, L.L.C., (Vandolah). The Interconnection Agreement was filed as a service agreement under Florida Power's open access transmission tariff (OATT), FERC Electric Tariff, First Revised Volume No. 6. The Interconnection Agreements set forth the terms and conditions governing the interconnection between Vandolah's yet-to-be constructed generating facility and the Company's transmission system, including the Company's construction of required interconnection facilities.

Florida Power requests a November 26, 2000 effective date.

Copies of the filing were served upon the El Paso Merchant Energy Company (Vandolah's partner in this generating facility project) and the Florida Public Service Commission.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

13. New England Power Pool

[Docket No. ER01–787–000]

Take notice that on December 26, 2000, the New England Power Pool (NEPOOL) Participants Committee tendered for filing and acceptance materials to permit NEPOOL to expand its membership to include Calpine Energy Services, L.P. (CES) and to terminate the membership of Calpine Power Services Company (CPS).

NEPOOL requests a November 1, 2000, effective date for the commencement of CES participation in and CPS termination from NEPOOL.

The Participants Committee states that copies of these materials were sent to the New England state governors and regulatory commissions and the Participants in NEPOOL.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

14. AES Medina Valley Cogen, L.L.C.

[Docket No. ER01–788–000]

Take notice that on December 26, 2000, AES Medina Valley Cogen, L.L.C. (Medina), Mossville, Illinois, tendered for filing with the Commission of a Service Agreement with Central Illinois Light Company to make energy sales pursuant to the terms of a Tolling Agreement.

Copies of the filing were served on the affected customer and the Illinois Commerce Commission.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

15. PJM Interconnection, L.L.C.

[Docket No. ER01–789–000]

Take notice that on December 26, 2000, PJM Interconnection, L.L.C. (PJM), on behalf of the PJM Reliability Committee, tendered for filing amendments to Sections 1.56, 10.2, and Schedules 5.2, and 7, of the Reliability Agreement Among Load Serving Entities in the PJM Control Area (RAA) to continue the current ALM credit treatment under the RAA after the Pool-Wide Choice Date and until May 31, 2001, and to modify the definition of ''Weighted Vote'' and the cost sharing provisions. The entire RAA also is filed in accordance with Order No. 614.

Copies of this filing were served upon all parties to the RAA and each state electric utility regulatory commission in the PJM control area.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

16. Avista Corp.

[Docket No. ER01–790–000]

Take notice that on December 26, 2000, Avista Corp., (AVA), tendered for filing with the Federal Energy Regulatory Commission executed Service Agreements for Short-Term Firm and Non-Firm Point-to-Point Transmission Service under AVA's Open Access Transmission Tariff—FERC Electric Tariff, Volume No. 8 with El Paso Merchant Energy, L.P.

AVA requests the Service Agreements be given a respective effective date of December 19, 2000

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

17. Allegheny Energy Supply Conemaugh, LLC

[Docket No. ER01–791–000]

Take notice that on December 26, 2000, Allegheny Energy Supply Conemaugh, LLC (Allegheny), tendered for filing a market rate tariff of general applicability under which it proposes to sell capacity and energy to affiliates and non-affiliates at market-based rates, and to make such sales to affiliates with franchised service areas at rates capped by a publicly available regional index price.

Allegheny requests an effective date no later than January 1, 2001.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

18. WPS Resources Operating Companies

[Docket No. ER01–792–000]

Take notice that on December 26, 2000, WPS Resources Operating Companies (WPSR), tendered for filing Notice of Cancellation for two Long-Term Firm Point-to-Point transmission service agreements under its open access transmission tariff, First Revised Volume No. 1 (OATT): one with Consolidated Water Power Company (CWP) and one with Wisconsin Public Power, Inc., (WPPI). WPSR seeks to cancel these two service agreements because under Wisconsin's electricity restructuring, the American Transmission Company, LLC (ATCLLC) will provide transmission service to these customers effective January 1, 2001.

WPSR requests that these cancellations take effect January 1, 2001.

Copies of the filing were served upon CWP, WPPI, Manitowoc Public Utilities, ATCLLC, the Michigan Public Service Commission and the Public Service Commission of Wisconsin.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

19. PacifiCorp

[Docket No. ER01–793–000]

Take notice that on December 26, 2000, PacifiCorp tendered for filing a Notice of Termination with the Federal Energy Regulatory Commission with respect to the Power Sales Agreement between PacifiCorp and Cheyenne Light, Fuel and Power Company dated June 21, 1995 (Agreement).

PacifiCorp requests that a waiver of prior notice be granted and that an effective date of December 31, 2000 be assigned to the Notice of Termination consistent with the termination date set forth in the Agreement.

Copies of this filing were supplied to Cheyenne and the Wyoming Public Service Commission.

Comment date: January 17, 2001, in accordance with Standard Paragraph E at the end of this notice.

20. Duke Electric Transmission, a division of Duke Energy Corporation

[Docket No. ER01–794–000]

Take notice that on December 27, 2000, Duke Electric Transmission (Duke ET), a division of Duke Energy Corporation tendered for filing an amendment to its open access transmission tariff, implementing interconnection procedures.

Duke requests that the proposed amendment be permitted to become effective on December 27, 2000.

Duke states that this filing is in accordance with Part 35 of the Commission's Regulations and a copy has been served on the North Carolina Utilities Commission and the South Carolina Public Service Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

21. American Transmission Company

[Docket No. ER01–795–000]

Take notice that on December 27, 2000, American Transmission Company LLC (ATCLLC), tendered for filing a Distribution-Transmission Interconnection Agreement between ATCLLC and Edison Sault Electric Company.

ATCLLC requests an effective date of January 1, 2001.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

22. Potomac Electric Power Company

[Docket No. ER01–796–000]

Take notice that on December 27, 2000, Potomac Electric Power Company (Pepco), tendered for filing pursuant to Section 205 of the Federal Power Act an executed Interconnection Agreement (Gude Facility), dated as of December 22, 2000, between Pepco and Pacific Energy Operating Group, L.P.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

23. PacifiCorp

[Docket No. ER01–797–000]

Take notice that on December 27, 2000, PacifiCorp tendered for filing in accordance with 18 CFR 35 of the Commission's Rules and Regulations, an unexecuted service agreement under its market-based tariff, PacifiCorp FERC Electric Tariff, Third Revised Volume No. 12.

PacifiCorp has requested an effective date of January 1, 2001.

Copies of this filing were supplied to the Wyoming Public Service Commission and the Public Utility Commission of Oregon.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

24. PacifiCorp

[Docket No. ER01–798–000]

Take notice that on December 27, 2000, PacifiCorp, tendered for filing in accordance with 18 CFR 35 of the Commission's Rules and Regulations,

revisions to Schedules 4, 7 and 8 as well as Attachment 7 to its open access transmission tariff, PacifiCorp's FERC Electric Tariff, Second Revised Volume No. 11 (Tariff). The revisions modify the procedures used in the handling of energy imbalances and transmission losses under the Tariff.

PacifiCorp has requested an effective date of January 1, 2001.

Copies of this filing were supplied to the Washington Utilities and Transportation Commission and the Public Utility Commission of Oregon.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

25. Duke Energy Corporation

[Docket No. ER01–799–000]

Take notice that on December 27, 2000, Duke Energy Corporation (Duke), tendered for filing a Service Agreement with the Tennessee Valley Authority, for Firm Transmission Service under Duke's Open Access Transmission Tariff.

Duke requests that the proposed Service Agreement be permitted to become effective on November 28, 2000.

Duke states that this filing is in accordance with Part 35 of the Commission's Regulations and a copy has been served on the North Carolina Utilities Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

26. Duke Energy Corporation

[Docket No. ER01–800–000]

Take notice that on December 27, 2000, Duke Energy Corporation (Duke), tendered for filing a Service Agreement with Duke Energy Trading and Marketing, L.L.C. for Firm Transmission Service under Duke's Open Access Transmission Tariff.

Duke requests that the proposed Service Agreement be permitted to become effective on November 28, 2000.

Duke states that this filing is in accordance with Part 35 of the Commission's Regulations and a copy has been served on the North Carolina Utilities Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

27. American Electric Power Service Corporation

[Docket No. ER01–801–000]

Take notice that on December 27, 2000, American Electric Power Service Corporation (AEPSC), tendered for filing Service Agreements under its Wholesale Market Tariff pursuant to which AEPSC may make power sales to certain affiliates to enable the companies to make sales to residential, commercial, and industrial retail customers in those states that have implemented retail access programs.

AEPSC requests an effective date of December 28, 2000.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

28. PECO Energy Company

[Docket No. ER01–802–000]

Take notice that on December 27, 2000, PECO Energy Company (PECO), tendered for filing under Section 205 of the Federal Power Act, 16 U.S.C. S 792 *et seq.*, an Agreement dated December 13, 2000 with Mack Services Group (MSG) under PECO's FERC Electric Tariff Original Volume No. 1 (Tariff).

PECO requests an effective date of December 13, 2000 for the Agreement.

PECO states that copies of this filing have been supplied to Mack Services Group and to the Pennsylvania Public Utility Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

29. PECO Energy Company

[Docket No. ER01–803–000]

Take notice that on December 27, 2000, PECO Energy Company (PECO), tendered for filing under Section 205 of the Federal Power Act, 16 U.S.C. S 792 *et seq.*, an Agreement dated December 21, 2000 with Louisiana Generating LLC. (LAG) under PECO's FERC Electric Tariff Original Volume No. 1 (Tariff).

PECO requests an effective date of December 21, 2000 for the Agreement.

PECO states that copies of this filing have been supplied to Louisiana Generating LLC and to the Pennsylvania Public Utility Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

30. PECO Energy Company

[Docket No. ER01–804–000]

Take notice that on December 27, 2000, PECO Energy Company (PECO), tendered for filing under Section 205 of the Federal Power Act, 16 U.S.C. S 792 *et seq.*, an Agreement dated December 19, 2000 with Green Mountain Energy Company (GMEC) under PECO's FERC Electric Tariff Original Volume No. 1 (Tariff).

PECO requests an effective date of December 19, 2000, for the Agreement.

PECO states that copies of this filing have been supplied to Green Mountain Energy Company and to the Pennsylvania Public Utility Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

31. California Independent System Operator Corporation

[Docket No. ER01–805–000]

Take notice that on December 27, 2000, the California Independent System Operator Corporation, tendered for filing a Scheduling Coordinator Agreement between the ISO and Sempra Energy Solutions for acceptance by the Commission.

The ISO states that this filing has been served on Sempra Energy Solutions and the California Public Utilities Commission.

The ISO is requesting waiver of the 60-day notice requirement to allow the Scheduling Coordinator Agreement to be made effective as of December 18, 2000.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

32. California Independent System Operator Corporation

[Docket No. ER01–806–000]

Take notice that on December 27, 2000, the California Independent System Operator Corporation (ISO), tendered for filing a Meter Service Agreement for Scheduling Coordinators between the ISO and Sempra Energy Solutions for acceptance by the Commission.

The ISO states that this filing has been served on Sempra Energy Solutions and the California Public Utilities Commission.

The ISO is requesting waiver of the 60-day notice requirement to allow the Meter Service Agreement to be made effective as of December 18, 2000.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

33. Wisconsin Public Service Corporation

[Docket No. ER01–807–000]

Take notice that on December 27, 2000, Wisconsin Public Service Corporation (WPSC) tendered a Notice of Cancellation of its Rate Schedule FERC No. 57, the 1995 ''Dewey Substation—Transmission Tap Payment Agreement'' with Wisconsin Power and Light Company (WPL).

WPSC requests waiver of the Commission's notice requirements so that this cancellation can be made effective January 1, 2001.

Copies of the filing were served upon WPL and the state commissions of Wisconsin and Michigan.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

34. Wisconsin Public Service Corporation

[Docket No. ER01–808–000]

Take notice that on December 27, 2000, Wisconsin Public Service Corporation (WPSC), tendered a Notice of Cancellation of its Rate Schedule FERC No. 45, an agreement with Wisconsin Power and Light Company (WPL) which provides for WPL to pay WPSC for WPSC's installation and construction of facilities to interconnect its Aurora Street Substation with WPL's transmission lines.

WPSC requests waiver of the Commission's notice requirements so that this cancellation can be made effective January 1, 2001.

Copies of the filing were served upon WPL, American Transmission Company, L.L.C. and the state commissions of Wisconsin and Michigan.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

35. WPS Resources Operating Companies

[Docket No. ER01–809–000]

Take notice that on December 27, 2000, WPS Resources Operating Companies (WPSR), tendered for filing revised executed service agreements with Madison Gas & Electric Company (MGE) and Wisconsin Public Power, Inc. (WPPI) for ancillary and distribution services under WPSR's open access transmission tariff, FERC Electric Tariff, First Revised Volume No. 1. WPSR also submits a notice of cancellation of WPPI's prior network service agreement under WPSC's predecessor transmission tariff.

WPSR requests waiver of the Commission's notice requirements to permit these documents to become effective on January 1, 2001.

Copies of the filing were served upon MGE, WPPI, the Michigan Public Service Commission and the Public Service Commission of Wisconsin.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

36. The Cincinnati Gas & Electric Company

[Docket No. ER01–810–000]

Take notice that on December 27, 2000, The Cincinnati Gas & Electric Company (CG&E), tendered for filing a Notice of Cancellation with Narrative Statement to terminate the Electric Service Agreement between CG&E and The West Harrison Gas and Electric Company (West Harrison).

CG&E requests that the termination be effective as of January 1, 2001, the date of the merger of West Harrison with PSI Energy, Inc., whereupon West Harrison will cease to exist as a legal entity.

Copies of the filing were served upon the affected customer and the Public Utilities Commission of Ohio and the Indiana Utility Regulatory Commission.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

37. Allegheny Energy Supply Company, LLC

[Docket No. ER01–811–000]

Take notice that on December 27, 2000, Allegheny Energy Supply Company, LLC (AE Supply), tendered for filing proposed amendments to its market rate tariff and code of conduct all as more fully described in the Application.

AE Supply requests an effective date of December 28, 2000.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

38. Geysers Power Company LLC

[Docket No. ER01–812–000]

Take notice that on December 27, 2000, Geysers Power Company, LLC (Geysers Power), tendered for filing its updated Rate Schedules for the calendar year 2001 for Reliability Must-Run services provided to the California Independent System Operator Corporation (CAISO) pursuant to the Geysers Main RMR Agreement accepted by the Commission in *California ISO Corp., et al.*, 87 FERC ¶ 61,250 (1999).

Copies of this filing have been served upon the CAISO, the California Public Utilities Commission, and Pacific Gas and Electric Company.

Comment date: January 18, 2001, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraphs

E. Any person desiring to be heard or to protest such filing should file a motion to intervene or protest with the Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of these filings are on file with the Commission and are available for public inspection. This filing may also be viewed on the Internet at *http://www.ferc.fed.us/online/rims.htm* (call 202–208–2222 for assistance).

David P. Boergers,

Secretary.

[FR Doc. 01–844 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP00–36–000]

Guardian Pipeline, L.L.C.; Notice of Availability of the Final Environmental Impact Statement for the Proposed Guardian Pipeline Project

January 5, 2001.

The staff of the Federal Energy Regulatory Commission (FERC or Commission) has prepared this final environmental impact statement (final EIS) on natural gas pipeline facilities proposed by Guardian Pipeline, L.L.C. (Guardian) in the above-referenced docket.

The final EIS was prepared to satisfy the requirements of the National Environmental Policy Act. The staff concludes that approval of the proposed project, with appropriate mitigating measures as recommended, would have limited adverse environmental impact. The final EIS evaluates alternatives to the proposal, including system alternatives; route alternatives; route variations, and minor route variations.

The final EIS addresses the potential environmental effects of the construction and operation of the following facilities in Illinois and Wisconsin:

- 141.3 miles of 36-inch-diameter pipeline extending from Joliet, Illinois to Ixonia, Wisconsin;
- 8.5 miles of 16-inch-diameter lateral pipeline in Walworth and Waukesha Counties, Wisconsin (Eagle Lateral);
- A total of 0.11, 24, and 16-inch-diameter pipeline to connect the project to existing pipeline systems in Will County, Illinois;

One 22,225-horsepower compressor station (Joliet Compressor Station) in Will County, Illinois;

- Seven new meter stations; and
- Associated pipeline facilities, including eight mainline valves.

The purpose of the Guardian Pipeline Project is to transport up to 750,000 decatherms per day of natural gas from the Chicago Hub to markets in northern Illinois and Wisconsin.

Wisconsin Gas Company (WGC) also proposes to construct about 35 miles of 30-, 24-, and 16-inch diameter pipeline (WGC Lateral Line Project) extending eastward from the northern terminus of the Guardian Pipeline in Wisconsin. WGC's Lateral Line Project is under the jurisdiction of the Public Service Commission of Wisconsin (PSCW). Although these facilities are not under the jurisdiction of the FERC, they are analyzed in this final EIS. The PSCW is participating in the EIS process as a cooperating agency, as is the Wisconsin Department of Natural Resources.

This final EIS has been placed in the public files of the FERC and is available for public inspection at: Federal Energy Regulatory Commission, Public Reference and Files Maintenance Branch, 888 First Street, NE., Washington, DC 20426, (202) 208–1371.

Copies of the final EIS have been mailed to Federal, state, and local agencies, public interest groups, individuals who have requested the final EIS, newspapers, and parties to this proceeding. In addition, a limited number of copies are available from the Public Reference and Files Maintenance Branch identified above.

Additional information about the proposed project is available from the Commission's Office of External Affairs, at (202) 208–1008 or on the FERC Internet website (*www.ferc.fed.us*) using the ''RIMS'' link to information in this docket number. Click on the ''RIMS'' link, select ''Docket #'' from the RIMS Menu, and follow the instructions. For assistance with access to RIMS, the RIMS helpline can be reached at (202) 208–2222.

Similarly, the ''CIPS'' link on the FERC Internet website provides access to the texts of formal documents issued by the Commission, such as orders, notices, and rulemakings. From the FERC Internet website, click on the ''CIPS'' link, select ''Docket #'' from the CIPS menu, and follow the instructions. For assistance with access to CIPS, the CIPS helpline can be reached at (202) 208–2474.

David P. Boergers,

Secretary.

[FR Doc. 01–868 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Transfer of License and Soliciting Comments, Motions To Intervene, and Protests

January 5, 2001.

Take notice that the following hydroelectric application has been filed with the Commission and is available for public inspection:

a. *Application Type:* Transfer of License.

b. *Project No.:* 11351–008.

c. *Date Filed:* September 26, 2000, as supplemented December 7, 2000.

d. *Applicants:* Debra Whitehead and William S. Woods.

e. *Name of Project:* Old Columbia Dam.

f. *Location:* On the Duck River in Columbia County, Tennessee. The project does not utilize federal or tribal lands.

g. *Filed Pursuant to:* Federal Power Act, 16 U.S.C. 791(a)–825(r).

h. *Applicant Contact:* William S. Woods, 505 Riverside Drive, Columbia, TN 38401, (931) 388–3292.

i. *FERC Contact:* Regina Saizan, (202) 219–2673.

j. *Deadline for filing comments and or motions:* January 31, 2001.

All documents (original and eight copies) should be fled with: David P. Boergers, Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426. Comments and protests may be filed electronically via the internet in lieu of paper. See, 18 CFR 385.2001(a)(1)(iii) and the instructions on the Commission's web site at *http://www.ferc.fed.us/efi/doorbell.htm.*

Please include the Project Number (11351–008) on any comments or motions filed.

k. *Description of Transfer:* The applicants seek Commission approval to transfer the license for the project, which was the subject of bankruptcy proceedings, to Mr. Woods. Mr. Woods purchased the project's generating equipment at an auction sale.

l. *Location of the Application:* A copy of the application is available for inspection and reproduction at the Commission's Public Reference Room, located at 888 First Street, NE., Room 2A, Washington, DC 20426, or by calling (202) 208–1371. This filing may be viewed on *http://www.ferc.fed.us/online/rims.htm* (call (202) 208–2222 for assistance). A copy is also available for inspection and reproduction at the address in item h above.

m. Individuals desiring to be included on the Commission's mailing list should so indicate by writing to the Secretary of the Commission.

Comments, Protests, or Motions to Intervene—Anyone may submit comments, a protest, or a motion to intervene in accordance with the requirements of Rules of Practice and Procedure, 18 CFR 385.210, .211, 214. In determining the appropriate action to take, the Commission will consider all protests or other comments filed, but only those who file a motion to intervene in accordance with the Commission's Rules may become a party to the proceeding. Any comments, protests, or motions to intervene must be received on or before the specified comment date for the particular application.

Filing and Service of Responsive Documents—Any filings must bear in all capital letters the title ''COMMENTS'', ''RECOMMENDATIONS FOR TERMS AND CONDITIONS'', ''PROTEST'', OR ''MOTION TO INTERVENE'', as applicable, and the Project Number of the particular application to which the filing refers. A copy of any motion to intervene must also be served upon each representative of the Applicant specified in the particular application.

Agency Comments—Federal, state, and local agencies are invited to file comments on the described application. A copy of the application may be obtained by agencies directly from the Applicant. If an agency does not file comments within the time specified for filing comments, it will be presumed to have no comments. One copy of an agency's comments must also be sent to the Applicant's representatives.

David P. Boergers,

Secretary.

[FR Doc. 01–863 Filed 1–10–01; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Statement of Organization, Functions and Delegations of Authority

Part A (Office of the Secretary), Chapter AE (Office of the Assistant Secretary for Planning and Evaluation (OASPE), of the Statement of Organization, Functions and Delegation of Authority for the Department of Health and Human Services (most recently amended at 63 FR 48 on March 12, 1998) is amended as follows:

I. Chapter AE, paragraph C. ''The Office of Health Policy,'' delete in its entirety and replace with the following:

C. The Office of Health Policy—The Office of Health Policy is responsible for policy development and coordination—including policy and long-range planning; policy, economic, program, and budget analyses; review of regulations and formulation of budget and legislation—and for the conduct and coordination of research, evaluation, and information dissemination on issues relating to health policy. In these matters, the office works closely with the Public Health Service components and the Health Care Financing Administration.

1. The Division of Health Financing Policy is responsible for functions related to the Department's health financing programs, primarily Medicare, SCHIP, and Medicaid and policies affecting health care financing and health care costs. Formulate and analyze alternative legislative and regulatory proposals: conduct short-term policy analyses and evaluations on the efficacy of existing and potential policies and programs in terms of cost, effectiveness and other variables; and synthesize technical analyses performed outside of the Government in a manner that is relevant to policy formulation.

2. The Division of Public Health Systems is responsible for functions related to public health programs and policies. Relevant topic areas include disease control; health promotion and disease prevention; health care resources development; health care and services delivery; alcohol, drug abuse and mental health services; as well as biomedical research and food and drug safety, to the extent these issues pertain to the application of public health practices. Conduct and prepare studies on the design and effectiveness of health promotion, disease prevention, and disease control activities undertaken by both the public and private sectors. Conduct policy research and evaluation studies characterizing the relationship between the medical services delivery system and population-based public health services, as well as examining the interaction of public health entities at all levels of government, to explore the structure, function, capacity, and practices of the public health system.

3. The Division of Health Delivery Systems is responsible for functions related to health services, health organizations and health delivery systems. Topics include consumer issues such as quality and consumer protections; private insurance; health care organization and financial issues. Analyze trends in the private health care sector; prepare and conduct studies on the interactions of the private and public health care sectors in terms of cost effectiveness, service levels and effects on consumers; analyze alternative legislative and regulatory proposals; prepare short-term policy analyses and evaluations of existing and potential policies and programs, particularly those that cut across the Department's program areas. The Division also coordinates work and plays a liaison role across the Department and with other Departments (including Treasury, Justice and Labor).

4. The Division of Health Policy Research and Planning is responsible for all functions related to the development of a comprehensive research, information, and analytical program to gain basic information in the areas of health services and financing focusing on health policy issues. Plan and implement health services and financing research to respond to OS analytic needs, including information sharing and coordination across Federal agencies and OPDIV's, and collaborations or partnerships with the health services research community. As part of this function the Division coordinates closely with other ASPE and OPDIV offices on health data and health information policy issues. The Division also works closely with the ASPE Division of Data Policy and OPDIV offices on the identification and coordination of cross-cutting health data information policy issues, and brings such issues to the HHS Data Council for consideration and resolution. The Division also directs, manages, and conducts a cross-cutting analyses, research, evaluation, and legislative and budget activities for health services and financing policy initiatives focusing on health policy issues.

II. Chapter AE, paragraph F. ''The Office of Science Policy,'' delete in its entirety and replace with the following:

F. The Office of Science Policy—The Office of Science Policy (OSP) is responsible for guiding and coordinating the development of science policy throughout the Department. As directed by the Secretary of the ASPE, OSP establishes and leads broadly representative, multi-office working groups to develop policy initiatives related to complex science and technology issues that cut across the missions of several entities within the Department. OSP generally leads these working groups in presentations to the Secretary, other senior DHHS staff, to members and/or staff of the Congress, and to others outside DHHS.

OSP is the OASPE lead on issues or initiatives that are heavily science-based, including public health issues that involve complex and/or rapidly evolving science and technology. OSP is responsible for guiding and coordinating the incorporation of science-policy considerations within regulatory proposals, legislative proposals, Congressional testimony, press releases, and other public documents describing major Departmental initiatives. OSP provides critique and advice regarding the science-policy content of such documents, which typically originate from DHHS Operating Divisions or other units within the Office of the Secretary. In selected instances, OSP initiates and directs the development of such documents.

OSP is responsible for creating and maintaining effective communication with scientific and technical communities outside the Department regarding science-policy issues. This includes liaison with the Office of Science and Technology Policy, Executive Office of the President. It also includes active participation in inter-agency science and technology activities (such as those sponsored by the National Science and Technology Council) and government/private-sector collaborations related to science policy (such as those sponsored by the National Academy of Sciences). These duties also include service as the Secretary's representative in meetings with leaders of research universities, scientific societies, professional associations, and industrial organizations involved in biomedical, behavorial, or social-science research or in the delivery of health and human services. In all of these areas, OSP staff coordinate their activities as appropriate with those of other components within OASPE; with other components and officials of the Office of the Secretary (including the Assistant Secretary for health in his/her role as the Secretary's senior advisor on public health and science); and with the Operating Divisions of the Department.

Dated: January 4, 2001.

John J. Callahan,

Assistant Secretary for Management and Budget.

[FR Doc. 01–787 Filed 1–10–01; 8:45 am]

BILLING CODE 4150–24–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–01–15]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call the CDC Reports Clearance Officer on (404) 639–7090.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques for other forms of information technology. Send comments to Anne O'Connor, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS–D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project

Alaska Air Carrier Operator and Pilot Survey—NEW—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC). The mission of the National Institute for Occupational Safety and Health is to promote safety and health at work for all people through research and prevention.

There is evidence that a disproportionate number of all U.S. aircraft crashes occur in Alaska. Between 1990–1998 there were 823 commuter and air taxi crashes in the U.S., of which 229 (28 percent) were fatal, resulting in 653 deaths. Alaska accounted for 304 (37 percent) of the total crashes, 49 of which were fatal (21 percent of the U.S. fatal crashes), resulting in 131 deaths (20 percent of all U.S. deaths) (NTSB Aviation Accident Database, 1999). Aviation crashes are now the leading cause of occupational fatalities in Alaska.

To address this compelling occupational issue in Alaska, Congress supported implementation of a federal initiative to reduce aviation-related injuries and fatalities. The initiative is a three-year commitment led by a partnership of four federal agencies who share an interest in promoting aviation safety and preventing aircraft crashes—the Federal Aviation Administration (FAA), the National Transportation Safety Board (NTSB), National Weather Service (NWS), and the National Institute for Occupational Safety and Health (NIOSH). The purpose of this joint initiative is to reduce the number of aircraft crashes and deaths, and promote aviation safety within the air transportation industry in Alaska.

This initiative complements another federal/industry initiative to reduce aviation fatalities—the Capstone Program. The Capstone Program, currently implemented in the Bethel, Alaska area includes installation of improved avionics in aircraft used in FAR Part 135 operations, an improved ground infrastructure for weather information, data link communications and Flight Information Services, and the development of new GIS-based non-precision instrument approaches at remote airports.

As part of these initiatives, air carrier operators and pilots will be surveyed to obtain information on what they perceive are the risks and hazards contributing to aircraft accidents in Alaska, their opinions about current safety programs, and what they think could be done to improve aviation safety. This information will be analyzed to identify common risk factors, compare them to risk factors identified from analysis of accident reports and published literature, and assess the effectiveness of current and new potential safety interventions. These findings will be useful to Alaska's air transportation industry for trend information to evaluate interventions.

To reduce the total respondent burden and increase efficiency in data collection, we are coordinating and combining the information gathering process for both the joint initiative and a safety study of the Capstone initiative into one effort. The joint initiative will conduct two statewide surveys: approximately 400 participants in the air carrier operator survey and 500 participants in the pilot survey. The Capstone safety study will add questions to both surveys for respondents in the implementation area, and in addition will continue to survey pilots using Capstone equipment for the duration of that program (through fall 2002). Follow up surveys to assess the effectiveness of the implementation measures would re-survey approximately half of the original statewide sample: about 200 air carrier operators and 250 pilots.

We will use the results of the initial statewide surveys to (1) recommend ways to improve air transportation safety; (2) identify measures to put the recommendations into effect; and (3) guide the ongoing research. Follow up surveys will assess the effectiveness of the program and identify potential improvements. We will use the results of the Capstone study surveys to assess the effectiveness of that program and to recommend improvements. The information can be obtained only from the respondents, as it requests information on skills, knowledge, attitudes, and business practices for which no other source is available.

Based on an average wage of $20.00 per hour for all respondents, the total annual cost is $15,400.

Survey	No. of respondents	No. of responses/ respondent	Avg. burden per response (in hrs.)	Total burden (in hrs.)
J1a. Statewide Operators	400	1	30/60	200
J2a. Statewide Pilots	500	1	30/60	250
C1. Additional questions: Capstone area operators	30	1	15/60	7.5
C2. Additional questions: Capstone area Pilots	50	1	15/60	12.5
C3. Capstone pilots not included in statewide survey	150	1	30/60	75
J1b. Post Implementation: Operators	200 (sample from J1a)	1	30/60	100

Survey	No. of respondents	No. of responses/ respondent	Avg. burden per response (in hrs.)	Total burden (in hrs.)
J2b. Post Implementation: Pilots	250 (sample from J1b)	1	30/60	125
Total				770

Dated: January 3, 2001.

Nancy Cheal,

Acting Associate Director for Policy, Planning and Evaluation Centers for Disease Control and Prevention (CDC).

[FR Doc. 01–915 Filed 1–10–01; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Prevention Education and Access to Care Services for Persons Infected and Affected by HIV

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting.

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Prevention Education and Access to Care Services for Persons Infected and Affected by HIV, Program Announcement ı01012, meeting.

Times and Dates: 9 a.m.–9:30 a.m., February 5, 2001 (Open). 9:30 a.m.–4:30 p.m., February 5, 2001 (Closed).

Place: National Center for HIV, STD, and TB Prevention, CDC, 8 Corporate Square Blvd., Conference Room 1A, B, and C, Atlanta, Georgia 30329.

Status: Portions of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Associate Director for Management and Operations, CDC, pursuant to Public Law 92–463.

Matters To Be Discussed: The meeting will include the review, discussion, and evaluation of applications received in response to Program Announcement #01012.

FOR FURTHER INFORMATION CONTACT: Elizabeth A. Wolfe, Prevention Support Office, National Center for HIV, STD, and TB Prevention, CDC, Corporate Square Office Park, 8 Corporate Square Boulevard, M/S E07, Atlanta, Georgia 30329, telephone 404/639–8025.

The Director, Management Analysis and Services office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: January 5, 2001.

Carolyn J. Russell,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention CDC.

[FR Doc. 01–914 Filed 1–10–01; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–2112–N]

Medicaid Program; Infrastructure Grant Program To Support the Competitive Employment of People With Disabilities

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

ACTION: Notice.

SUMMARY: This notice announces the availability of our funding, through grants, for eligible States under the Ticket to Work and Work Incentives Improvement Act of 1999. The grant program is designed to assist States in developing infrastructures to support the competitive employment of people with disabilities by extending necessary Medicaid coverage to these individuals. This notice also contains pertinent information where States may apply for the grant program.

DATES: States should submit a notice of intent to apply for a grant no later than March 15, 2001.

Deadline for Grant Submission: Grant applications must be submitted by May 21, 2001 to be considered under the Fiscal Year 2002 annual funding cycle.

ADDRESSES: Standard application forms and related instructions are available from and must be formally submitted to: Marilyn Lewis-Taylor, Health Care Financing Administration, Office of Internal Customer Support, AGG, Grants Management Staff, Mail Stop C2–15–21, 7500 Security Boulevard, Baltimore, Maryland 21244–1850, (410) 786–5701, Internet:*Mlewistaylor@hcfa.gov.*

Please note: While State agencies are only required to submit an original and two copies, submission of an original and *14 copies* will greatly expedite the application process.

Website: You may access up-to-date information about the Medicaid Infrastructure Grants and obtain a complete Grant Solicitation at: *http://www.hcfa.gov/medicaid/twwiia/twwiiahp.htm.*

FOR FURTHER INFORMATION CONTACT: Questions about the grants may be directed to: Joe Razes, TWWIIA Program Manager, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Health Care Financing Administration, Room S2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, (410) 786–6126, Internet:JRazes@hcfa.gov.

SUPPLEMENTARY INFORMATION: On May 31, 2000, we published a notice in the **Federal Register** (65 FR 34715) to announce our availability of funding, through grants, for eligible States under the Ticket to Work and Work Incentives Improvement Act of 1999. In that notice, we solicited eligible States to apply for those grants to provide financial assistance for the Competitive Employment of People with Disabilities under the Medicaid program. States that wish to apply for these grants and desire further detailed information, such as application requirements, review procedures, an explanation of a timely submission, and other relevant information, should refer to the above-mentioned **Federal Register** notice and Website listed.

Authority: Section 203 of the Ticket to Work and Work Incentive Improvement Act of 1999, Public Law 106–170. (Catalog of Federal Domestic Assistance Program No. 93.779, Health Care Financing Research, Demonstration, and Evaluations)

Dated: January 5, 2001.

Robert A. Berenson,

Acting Deputy Administrator, Health Care Financing Administration.

[FR Doc. 01–814 Filed 1–10–01; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Proposed Collection; Comment Request; Validation of Questionnaires Used for Occupational Exposure Assessment in Case-Control Studies: Occupational History Questionnaire With Foundry Worker and Textile Industry Job Modules

SUMMARY: In compliance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, for opportunity for public comment on proposed data collection projects, the National Cancer Institute (NCI) will publish periodic summaries of proposed projects to be submitted to the Office of Management and Budget (OMB) for review and approval.

Proposed Collection

Title: Validation of Questionnaires Used for Occupational Exposure Assessment in Case-Control Studies: Occupational History Questionnaire with Foundry Worker and Textile Industry Job Modules.

Type of Information Collection Request: New.

Need and Use of Information Collection: This study will investigate the validity and reliability of exposure assessments based on occupational history questionnaires supplemented with industry specific job modules as compared to exposure assessments made based on actual measurement taken in the workplace environments. The results will be used to assess the potential magnitude of exposure misclassification in case-control studies using these types of exposure assessment methods.

Frequency of Response: One time study.

Affected Public: Large and small factories in Shanghai, China.

Type of Respondents: Factory workers.

The annual burden is as follows:

Estimated Number of Respondents: 120.

Estimated Number of Responses per Respondent: 1.

Average Burden Hours per Respondent: 0.5 hours.

Estimated Total Annual Burden Hours Requested: 60.

Request for Comments

Written comments and/or suggestions from the public and affected agencies are invited on one or more of the following points: (1) Whether the proposed collection of information is necessary for the proper performance of the agency, including whether the information will have practical utility; (2) The accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (3) Ways to enhance the quality, utility and clarity of the information to be collected; and (4) Ways to enhance the quality, utility and clarity of the information to be collected; and (4) Ways to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Comments Due Date

Comments regarding this information collection are best assured of having their full effect if received on or before March 12, 2001.

FOR FURTHER INFORMATION CONTACT: To request more information on the proposed project or to obtain a copy of the data collection plans and instruments, contact Dr. Joseph Coble, Project Officer, National Cancer Institute, 6120 Executive Blvd, EPS 8110, Rockville, MD 20892–7240, or call non-toll free number (301) 435–4702, email your request to *jcoble@mail.nih.gov.*

Dated: January 3, 2001.

Reesa Nichols,

NCI Project Clearance Liaison.

[FR Doc. 01–801 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Opportunity for a Cooperative Research and Development Agreement (CRADA) for the Identification and Development of Chemical Compounds That Interact With the Polo-Box of Polo Kinases, as Potential Therapeutic Targets for the Inhibition of Cellular Proliferation

National Cancer Institute (NCI) has extended the deadline for submission of written notices and proposals regarding the CRADA opportunity described in the **Federal Register** Notice number 213, volume 65, dated November 2, 2000.

AGENCY: National Institutes of Health, PHS, DHHS.

ACTION: Notice of extension of announcement of opportunity for a Cooperative Research and Development Agreement (CRADA) for the identification and development of chemical compounds that interact with the polo-box of polo kinases, as potential therapeutic targets for the inhibition of cellular proliferation.

SUMMARY: Members of the polo subfamily of protein kinases play important roles in cell proliferation, and regulation of polo kinases may be crucial in the control of cell division. The polo kinases contain a distinct region of homology in the C-terminal non-catalytic domain, termed the polo-box. Scientists from the National Cancer Institute (NCI) have demonstrated that over-expression of this non-catalytic C-terminal domain in budding yeast results in a dominant-negative inhibition of cell division. NCI seeks a Cooperative Research and Development Agreement (CRADA) Collaborator to aid in the identification and development of chemical compounds that interact with the polo-box of polo kinases, as potential therapeutic targets for the inhibition of cellular proliferation.

DATES: Interested parties should notify this office in writing of their interest in filing a formal proposal on or before March 12, 2001. Potential CRADA Collaborators will then have until on or before April 11, 2001 to submit a formal proposal. CRADA proposals submitted thereafter may be considered if a suitable CRADA Collaborator has not been selected.

ADDRESSES: Inquiries and proposals regarding this opportunity should be addressed to Laura A. Henmueller, Ph.D., Technology Development Specialist (Tel: 301–496–0477, FAX: 301–402–2117), Technology Development and Commercialization Branch, National Cancer Institute, 6120 Executive Blvd., Suite 450, Rockville, MD 20852. Inquiries directed to obtaining patent license(s) needed for participation in the CRADA opportunity should be addressed to Vasant Gandhi, J.D., Ph.D., Technology Licensing Specialist, Office of Technology Transfer, National Institutes of Health, 6011 Executive Blvd., Suite 325, Rockville, MD 20852, (Tel: 301–496–7056, ext. 224, FAX: 301–402–0220).

SUPPLEMENTARY INFORMATION: A Cooperative Research and Development Agreement (CRADA) is the anticipated joint agreement to be entered into with NCI pursuant to the Federal Technology Transfer Act of 1986 and Executive Order 12591 of April 10, 1987 as amended. NCI is looking for a CRADA partner to aide NCI in the identification and development of chemical compounds which act as polo-box inhibitors. The expected duration of the

CRADA would be from one (1) to five (5) years.

Members of the polo subfamily of protein kinases appear to play pivotal roles in cell division and proliferation. These include mammalian Plk, Snk, and Fnk/Prk, *Xenopus laevis* Plx1, *Drosophila melanogaster* polo, *Schizosaccharomyces pombe* Plo1, and *Saccharomyces cerevisiae* Cdc5. The polo subfamily members are characterized by the presence of a distinct region of homology in the C-terminal non-catalytic domain, termed the polo-box, which is essential for subcellular localization and mitotic functions of the polo kinases. Regulation of polo kinases may be crucial in the control of cell division. In mammalian cells, Plk is expressed at high levels in mitotically active cells and in tumors of various origins. Constitutive expression of Plk in NIH3T3 cells induces oncogenic focus formation, and these Plk-transformed cells can form tumors in nude mice. These data suggest that Plk expression is closely related to cellular proliferation, and that uncontrolled Plk expression may lead to the development of cancers in humans. Genetic and biochemical analyses indicate that polo kinases regulate diverse cellular events at various stages of the M phase. In addition to their roles in spindle formation and centrosome maturation, polo kinases appear to regulate important biochemical steps at the G2/M transition, such as activation of Cdc2 through Cdc25C phosphatase, DNA damage checkpoint adaptation, and activation of the anaphase-promoting complex (APC) in various eukaryotic systems. In addition, recent data suggest that polo kinases play important roles in cytokinesis.

In budding yeast, overexpression of the non-catalytic C-terminal domain of either Plk or Cdc5 (plkΔN or cdc5ΔN), but not the corresponding polo-box mutant, results in severe connected cell morphology. Provision of functional Cdc5 remedies this phenotype, indicating that over-expression of *cdc*5Δ*N* or *plk*Δ*N* results in a dominant-negative inhibition of cell division and that an intact polo-box is required for this event. These data raise an intriguing possibility that conditional expression of the polo-box domain may selectively inhibit the mitotic functions of polo kinases. Furthermore, our observation suggests that the polo-box peptide may act as a potential anti-cancer therapeutic agent. Alternatively, isolation of small chemical compounds that bind to the polo-box and interfere with its function may yield a strategy to regulate highly proliferative malignant cells. We have developed two yeast strains that conditionally express the polo-box domains of Plk (KLY1212) or Cdc5 (KLY1083). Isolation of chemical compounds alleviating the dominant-negative cell division defect of these strains may lead to identification of polo-box inhibitors. Since the polo-box is an essential and unique domain for polo kinases, these inhibitors may likely provide selective tools to control the cell proliferation without interfering with other protein kinases.

The described methods are the subject of a U.S. provisional patent application filed May 23, 2000 by the Public Health Service on behalf of the Federal Government. Furthermore, the initial report and characterization of the invention is described in: Song S, and Lee KS. A novel function of *Saccharomyces cerevisiae* CDC5 in cytokinesis (submitted for publication). Further reference to the invention can be found in: (1) Song S, Grenfell TZ, Garfield S, Erikson RL, and Lee KS. (2000). Essential function of the polo box of Cdc5 in subcellular localization and induction of cytokinetic structures. Mol. Cell. Biol. 20, 286–298, and (2) Lee KS, Grenfell TZ Yarm, FR, and Erikson RL (1998). Mutation of the polo-box disrupts localization and mitotic functions of the mammalian polo kinase Plk. Proc. Natl. Acad. Sci. USA 95:9301–9306.

Under the present proposal, the goal of the CRADA will involve the following:

(1) Identification and isolation of chemical compounds that alleviate the dominant-negative cell division defect of yeast strains that conditionally express the polo-box domains of Plk or Cdc5.

(2) Development of these chemical compounds as tools to control cellular proliferation without interfering with other protein kinases.

Party Contributions

The role of the NCI in the CRADA may include, but not be limited to:

1. Providing intellectual, scientific, and technical expertise and experience to the research project.

2. Providing the CRADA Collaborator with information and data relating to polo kinases.

3. Planning research studies and interpreting research results.

4. Carrying out research which validates and expands on the role of the dominant-negative inhibition of cell proliferation found using the intact polo-box.

5. Publishing research results.

6. Developing additional potential applications related to inhibition of cell proliferation using polo-box inhibitors.

The Role of the CRADA Collaborator May Include, but Not Be Limited To:

1. Providing significant intellectual, scientific, and technical expertise or experience to the research project.

2. Planning research studies and interpreting research results.

3. Providing technical and/or financial support to facilitate scientific goals and for further design of applications of the technology outlined in the agreement.

4. Publishing research results.

Selection Criteria for choosing the CRADA collaborator may include, but not be Limited to:

1. A demonstrated record of success in the areas of isolation, purification, characterization, and therapeutic development of chemical compounds.

2. A demonstrated background and expertise in cancer-related sciences.

3. The ability to collaborate with NCI on further research and development of this technology. This ability will be demonstrated through experience and expertise in this or related areas of technology indicating the ability to contribute intellectually to ongoing research and development.

4. The demonstration of adequate resources to perform the research and development of this technology (*e.g.* facilities, personnel and expertise) and to accomplish objectives according to an appropriate timetable to be outlined in the CRADA Collaborator's proposal.

5. The willingness to commit best effort and demonstrated resources to the research and development of this technology, as outlined in the CRADA Collaborator's proposal.

6. The demonstration of expertise in the commercial development and production of products related to this area of technology.

7. The level of financial support the CRADA Collaborator will provide for CRADA-related Government activities.

8. The willingness to cooperate with the National Cancer Institute in the timely publication of research results.

9. The agreement to be bound by the appropriate DHHS regulations relating to human subjects, and all PHS policies relating to the use and care of laboratory animals.

10. The willingness to accept the legal provisions and language of the CRADA with only minor modifications, if any. These provisions govern the distribution of future patent rights to CRADA inventions. Generally, the rights of ownership are retained by the organization that is the employer of the inventor, with (1) the grant of a license

for research and other Government purposes to the Government when the CRADA Collaborator's employee is the sole inventor, or (2) the grant of an option to elect an exclusive or nonexclusive license to the CRADA Collaborator when the Government employee is the sole inventor.

Dated: December 19, 2000.

Kathleen Sybert,

Chief, Technology Development and Commercialization Branch, National Cancer Institute, National Institutes of Health.

[FR Doc. 01–813 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Training Grant and Career Development Review Committee.

Date: February 1–2, 2001.

Time: 8:00 am to 5:00 pm.

Agenda: To review and evaluate grant applications.

Place: Melrose Hotel, 2430 Pennsylvania Avenue, N.W., Washington, DC 20037.

Contact Person: Raul A. Saavedra, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–496–9223.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–802 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant application, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Neurological Disorders and Stroke Special Emphasis Panel.

Date: January 9, 2001.

Time: 2:00 pm to 4:00 pm.

Agenda: To review and evaluate grant applications.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Raul A. Saavedra, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Research, NINDS/NIH/DHHS, Neuroscience Center, 6001 Executive Blvd., Suite 3208, MSC 9529, Bethesda, MD 20892–9529, 301–496–9223.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–803 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Council on Drug Abuse.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Council on Drug Abuse.

Date: February 13–14, 2001.

Closed: February 13, 2001, 1 pm to 5:30 pm.

Agenda: To review and evaluate grant applications.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892.

Open: February 14, 2001, 9 am to 4:30 pm.

Agenda: This portion of the meeting will be open to the public for announcements and reports of administrative, legislative and program developments in the drug abuse field.

Place: Neuroscience Center, National Institutes of Health, 6001 Executive Blvd., Bethesda, MD 20892.

Contact Person: Teresa Levitin, PhD, Director, Office of Extramural Affairs, National Institute on Drug Abuse, National Institutes of Health, DHHS, Bethesda, MD 20892–9547, (301) 443–2755.

(Catalogue of Federal Domestic Assistance Program Nos. 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards; 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–804 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Environmental Health Sciences; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Environmental Health Sciences Special Emphasis Panel Program Project Reviews.

Date: February 5–7, 2001.

Time: 7:00 PM to 12:00 PM.

Agenda: To review and evaluate grant applications.

Place: Double Tree Hotel Atlanta-Buckhead, 3342 Peachtree Road, NE, Atlanta, GA 30326.

Contact Person: Ethel B. Jackson, DDS, Chief, Scientific Review Branch, Office of Program Operations, Division of Extramural Research and Training, Nat. Institute of Environmental Health Sciences, P.O. Box 12233, MD EC–30, Research Triangle Park, NC 27709, (919) 541–7826.

(Catalogue of Federal Domestic Assistance Program Nos. 93.113, Biological Response to Environmental Health Hazards; 93.114, Applied Toxicological Research and Testing; 93.115, Biometry and Risk Estimation—Health Risks from Environmental Exposures; 93.142, NIEHS Hazardous Waste Worker Health and Safety Training; 93.143, NIEHS Superfund Hazardous Substances—Basic Research and Education; 93.894, Resources and Manpower Development in the Environmental Health Sciences, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–805 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Neurological Disorders and Stroke; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of a meeting of the National Advisory Neurological Disorders and Stroke Council.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Neurological Disorders and Stroke Council.

Date: February 15–16, 2001.

Open: February 15, 2001, 10:30 a.m. to 4:30 p.m.

Agenda: Report by the Acting Director, NINDS; Report by the Director, Division of Extramural Research; and other administrative and program developments.

Place: 45 Center Drive, Natcher Building, Conference Room E1/2, Bethesda, MD 20892.

Closed: February 15, 2001, 4:30 p.m. to 5:30 p.m.

Agenda: To review and evaluate the Division of Intramural Research Board of Scientific Counselors' reports.

Place: 45 Center Drive, Natcher Building, Conference room E1/2, Bethesda, MD 20892.

Closed: February 16, 2001, 8:30 a.m. to 12 p.m.

Agenda: To review and evaluate grant applications.

Place: 45 Center Drive, Natcher Building, Conference Room E1/2, Bethesda, MD 20892.

Contact Person: Constance W. Atwell, PhD, Associate Director for Extramural Research, National Institute of Neurological Disorders and Stroke, National Institutes of Health, Neuroscience Center, 6001 Executive Blvd., Suite 3309, MSC 9531, Bethesda, MD 20892–9531, (301) 496–9248.

(Catalogue of Federal Domestic Assistance Program Nos. 93.853, Clinical Research Related to Neurological Disorders; 93.854, Biological Basis Research in the Neurosciences, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–806 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institutes of Health; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Mental Health Special Emphasis Panel.

Date: February 13–14, 2001.

Time: 8:30 a.m. to 5:30 p.m.

Agenda: To review and evaluate grant applications.

Place: Governor's House, 1615 Rhode Island Avenue, NW., Washington, DC 20036.

Contact Person: David I. Sommers, PhD., Scientific Review Administrator, Division of Extramural Activities, National Institutes of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6144, MSC 9606, Bethesda, MD 20892–9606, 301–443–6470.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–807 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Diabetes and Digestive and Kidney Diseases; Notice of Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2), notice is hereby given of meetings of the National Diabetes and Digestive and Kidney Diseases Advisory Council.

The meetings will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation of other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council.

Date: February 7–8, 2001.

Open: February 7, 2001, 8:30 AM to 12:00 PM.

Agenda: Present the Director's Report and other scientific presentations.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Closed: February 7, 2001, 2:30 PM to adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Closed: February 8, 2001, 9:45 AM to 10:15 AM.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Open: February 8, 2001, 10:15 AM to 12:00 PM.

Agenda: Present the Director's Report and other scientific presentations.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Contact Person: Robert D. Hammond, PhD, Director For Extramural Activities, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, 6707 Democracy Blvd, Room 631, MSC 5452, Bethesda, MD 20892–5452, 301–594–8834, rh53k@nih.gov

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council, Digestive Diseases and Nutrition Subcommittee.

Date: February 7–8, 2001.

Open: February 7, 2001, 1:30 PM to 2:30 PM.

Agenda: Review of the Division's scientific and planning activities.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31A, Conference Room 9A51, Bethesda, MD 20892.

Closed: February 7, 2001, 2:30 PM to adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31A, Conference Room 9A51, Bethesda, MD 20892.

Closed: February 8, 2001, 8:00 AM to 9:30 AM.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31A, Conference Room 9A51, Bethesda, MD 20892.

Contact Person: Robert D. Hammond, PhD, Director for Extramural Activities, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, 6707 Democracy Blvd, Room 631, MSC 5452, Bethesda, MD 20892–5452, 301–594–8834, rh53k@nih.gov

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council, Endocrine and Metabolic Diseases Subcommittee.

Date: February 7–8, 2001.

Open: February 7, 2001, 1:30 PM to 2:30 PM.

Agenda: Review of the Division's scientific and planning activities.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Closed: February 7, 2001, 2:30 PM to adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Closed: February 8, 2001, 8:00 AM to 9:30 AM.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, Conference Room 10, Bethesda, MD 20892.

Contact Person: Robert D. Hammond, PhD, Director for Extramural Activities, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, 6707 Democracy Blvd, Room 631, MSC 5452, Bethesda, MD 20892–5452, 301–594–8834, rh53k@nih.gov

Name of Committee: National Diabetes and Digestive and Kidney Diseases Advisory Council, Kidney, Urologic and Hematologic Diseases Subcommittee.

Date: February 7–8, 2001.

Open: February 7, 2001, 1:30 PM to 2:30 PM.

Agenda: Review of the Division's scientific and planning activities.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31C, Conference Room 7, Bethesda, MD 20892.

Closed: February 7, 2001, 2:30 PM to adjournment.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31C, Conference Room 7, Bethesda, MD 20892.

Closed: February 8, 2001, 8:00 AM to 9:30 AM.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31C, Conference Room 7, Bethesda, MD 20892.

Contact Person: Robert D. Hammond, PhD, Director for Extramural Activities, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, 6707 Democracy Blvd, Room 631, MSC 5452, Bethesda, MD 20892–5452, 301–594–8834, rh53k@nih.gov

(Catalogue of Federal Domestic Assistance Program Nos. 93.847, Diabetes, Endocrinology and Metabolic Research; 93.848, Digestive Diseases and Nutrition Research; 93.849, Kidney Diseases, Urology and Hematology Research, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–809 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2), notice is hereby given of a meeting of the National Advisory Council on Alcohol Abuse and Alcoholism.

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contract Person listed below in advance of the meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the

discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Advisory Council on Alcohol Abuse and Alcoholism.

Date: February 7–8, 2001.

Closed: February 7, 2001, 7:00 PM to 9:00 PM.

Agenda: To review and evaluate grant applications and/or proposals.

Place: Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, MD 20814.

Open: February 8, 2001, 8:30 AM to 3:00 PM.

Agenda: Program documents.

Place: Natcher Building, 45 Center Drive, Conference Rooms E1/E2, Bethesda, MD 20892.

Contact Person: James F. Vaughan, Executive Secretary.

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–810 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel.

Date: February 8–9, 2001.

Time: February 8, 2001, 8 AM to 6 PM.

Agenda: To review and evaluate grant applications.

Place: Ramada Inn, 1775 Rockville Pike, Rockville, MD 20852.

Contact Person: L. Tony Beck, PhD, Scientific Review Administrator, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Blvd, MSC 7003, Bethesda, MD 20892–7003, 301–443–0931, lbeck@mail.nihg.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–811 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Initial Review Group, Health Services Research Review Subcommittee.

Date: February 15, 2001.

Time: 8:30 AM to 5 PM.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn, Bethesda, MD 20814.

Contact Person: Elsie Taylor, Scientific Review Administrator, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Blvd., Bethesda, MD 20892–7003, 301–443–9787, etaylor@niaaa.nih.gov.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Initial Review Group, Clinical and Treatment Subcommittee.

Date: February 22–23, 2001.

Time: 8:30 AM to 5:00 PM.

Agenda: To review and evaluate grant applications.

Place: Pooks Hill Marriott, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Elsie Taylor, Scientific Review Administrator, Extramural Project Review Branch, National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Suite 409, 6000 Executive Blvd., Bethesda, MD 20892–7003, 301–443–9787, etaylor@niaaa.nih.gov.

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–812 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 8, 2001.

Time: 1:00 PM to 2:30 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Stephen M. Nigida, PhD, Scientific Review Administrator, Center for

Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4112, MSC 7812, Bethesda, MD 20892, (301) 435–3565.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 9, 2001.

Time: 9:00 AM to 5:00 PM.

Agenda: To review and evaluate grant applications.

Place: Jurys Washington Hotel, Washington, DC 20036.

Contact Person: Carl D. Banner, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5212, MSC 7850, Bethesda, MD 20892, (301) 435–1251, bannerc@drg.nih.gov.

This notice is being published less than 15 days prior to the meting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 9, 2001.

Time: 10:00 AM to 12 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Mary Clare Walker, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5104, MSC 7852, Bethesda, MD 20892, (301) 435–1165.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Time: 1:00 PM to 3:00 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contract Person: Alexander D. Politis, Phd, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4204, MSC 7812, Bethesda, MD 20892, (301) 435–1225, politisa@mail.nih.gov

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 10, 2001.

Time: 2:00 PM to 3:30 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call)

Contact Person: Betty Hayden, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, room 4206, MSC 7812, Bethesda, MD 20892, (301) 435–1223, haydenb@csr.nih.gov

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 11, 2001.

Time: 9:30 AM to 12:00 PM

Agenda: To review and evaluate grant applications

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call)

Contact Person: Syed Quadri, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4144, MSC 7804 Bethesda, MD 20892 (301) 435–1211

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel

Date: January 11, 2001

Time: 3:00 PM to 5:00 PM

Agenda: To review and evaluate grant applications

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call)

Contact Person: Philip Perkins, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4148, MSC 7804, Bethesda, MD 20892 (301) 435–1718

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel

Date: January 16, 2001

Time: 10:30 AM to 12:00 PM

Agenda: To review and evaluate grant applications

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call)

Contact Person: Dharam S. Dhindsa, DVM, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5126, MSC 7854, Bethesda, MD 20892, (301) 435–1174, dhindsad@csr.nih.gov

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Oncological Sciences Integrated Review Group Chemical Pathology Study Section

Date: January 17–19, 2001

Time: 8:30 AM to 5:00 PM

Agenda: To review and evaluate grant applications

Place: Clarion Ventura Beach Hotel, 2055 Harbor Boulevard, Ventura, CA 93001

Contact Person: Victor A. Fung, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4120, MSC 7804, Bethesda, MD 20892, 301–435–3504, fungv@csr.nih. gov

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel

Date: January 18, 2001

Time: 3:00 PM to 5:00 PM

Agenda: To review and evaluate grant applications

Place: NIH, Rockledge 2, Bethesda, MD 20892 (Telephone Conference Call)

Contact Person: Philip Perkins, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4148, MSC 7804, Bethesda, MD 20892 (301) 435–1718

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel

Date: January 20, 2001

Time: 7:30 AM to 5:30 PM

Agenda: To review and evaluate grant applications

Place: Fairmont Hotel, San Jose 170 South Market Street, San Jose, CA 95113

Contact Person: Eugene Vigil, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health 6701 Rockledge Drive, Room 5144, MSC 7840, Bethesda, MD 20892 (301) 435–1025

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel

Date: January 21, 2001

Time: 7:30 AM to 1:00 PM

Agenda: To review and evaluate grant applications

Place: Fairmont Hotel, San Jose, 170 South Market Street, San Jose, CA 95113

Contact Person: Eugene Vigil, PhD, Scientific Reivew Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5144, MSC 7840, Bethesda, MD 20892 (301) 435–1025

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 93.333, 93.337, 93.393–93396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: January 2, 2001.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–799 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 3, 2001.

Time: 12 PM to 2 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Elliot Postow, PHD, Scientific Review Administrator, Division of Clinical and Population-Based Studies, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4160, MSC 7806, Bethesda, MD 20892, (301) 435–0911, postowe@csr.nih.gov.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: Center for Scientific Review Special Emphasis Panel.

Date: January 4, 2001.

Time: 2 PM to 5 PM.

Agenda: To review and evaluate grant applications.

Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Joanne T. Fujii, PHD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5218, Bethesda, MD 20892, (301) 435–1178, fujiij@drg.nih.gov.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

(Catalogue of Federal Domestic Assistance Program Nos. 93.306, Comparative Medicine, 93.306; 93.333, Clinical Research, 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893, National Institutes of Health, HHS)

Dated: January 2, 2001.

Anna Snouffer,

Acting Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–800 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Clinical Center; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. appendix 2), notice is hereby given of a meeting of the Board of Scientific Counselors of the Warren Grant Magnuson Clinical Center.

The meeting will be closed to the public as indicated below in accordance with the provisions set forth in section 552b(c)(6), Title 5 U.S.C., as amended for the review, discussion, and evaluation of individual intramural programs and projects conducted by the Clinical Center, including consideration of personnel qualifications and performance, and the competence of individual investigators, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: The Board of Scientific Counselors of the Warren Grant Magnuson Clinical Center.

Date: February 12–13, 2001.

Time: 8:00 AM to 5:00 PM.

Agenda: To review and evaluate personal qualifications and performance, and competence of individual investigators.

Place: National Institutes of Health, Clinical Center Medical Board Room, 2C116, 9000 Rockville Pike, Bethesda, MD 20892.

Contact Person: David K. Henderson, MD, Deputy Director for Clinical Care, Office of the Director, Clinical Center, National Institutes of Health, Building 10, Room 2C146, Bethesda, MD 20892, 301/402–0244.

Dated: January 4, 2001.

LaVerne Y. Stringfield,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 01–808 Filed 1–10–01; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HOUSING AND URBAN AND DEVELOPMENT

[Docket No. FR–4561–N–85]

Notice of Submission of Proposed Information Collection to OMB; Multifamily Coinsurance Claims Packages, Section 223(f)

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proopsal.

DATES: *Comments Due Date:* March 12, 2001.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2502–0420) and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Q, Department of Housing and Urban Development, 451 Seventh Street, Southwest, Washington, DC 20410; e-mail *Wayne_Eddins@HUD.gov;* telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proosal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of responses, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of

an information collection requirement; and (10) the name and telephone number of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

This Notice also lists the following information:

Title of Proposal: Multifamily Coinsurance Claims Pacakage, Section 223(f).

OMB Approval Number: 2502–0420.

Form Numbers: HUD–27008, 27009B, 27009D, 27009F.

Description of the Need for the Information and Its Proposed Use: Mortgagees submit Section 223(f) Coinsurance Claims when an insured mortgage is defaulted. HUD computes the claim settlement due the mortgage from the information collected on the subject package.

Respondings: Business or other for-profit, State, Local or Tribal Government.

Frequency of Submission: On occasion.

Reporting Burden:

Number of respondents	x	Frequency of response	×	Hours of response	=	Burden hours
12		1		6		72

Total Estimated Burden Hours: 72.

Status: Reinstatement, with change.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: January 4, 2001.

Wayne Eddins,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 01–796 Filed 1–10–01; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4561–N–86]

Notice of Submission of Proposed Information Collection to OMB Final Endorsement of Credit Instrument

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* February 12, 2001.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2502–0016) and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Q, Department of Housing and Urban Development, 451 Seventh Street, Southwest, Washington, DC 20410; e-mail Wayne_Eddins@HUD.gov; telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the name and telephone number of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

This Notice also lists the following information:

Title of Proposal: Final Endorsement of Credit Instrument.

OMB Approval Number: 2502–0016.

Form Numbers: HUD–92023.

Description of the Need for the Information and its Proposed Use: Request by a mortgagee for final endorsement by HUD for Project insurance and for disbursement of the final advance.

Respondents: Business or other for-profit, Not-for-profit institutions.

Frequency of Submission: Reporting.

Reporting Burden:

Number of respondents	×	Frequency of response	×	Hours per response	=	Burden hours
465		1		1		465

Total Estimated Burden Hours: 465.

Status: Reinstatement, without change.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: January 4, 2001.

Wayne Eddins,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 01–797 Filed 1–10–01; 8:45am]

BILLING CODE 4210–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4561–N–87]

Notice of Submission of Proposed Information Collection to OMB; Previous Participation Certification

AGENCY: Office of the Chief Information Officer, HUD.

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below has been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposal.

DATES: *Comments Due Date:* February 12, 2001.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB approval number (2502–0118) and should be sent to: Joseph F. Lackey, Jr., OMB Desk Officer, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Wayne Eddins, Reports Management Officer, Q, Department of Housing and Urban Development, 451 Seventh Street, Southwest, Washington, DC 20410; e-mail Wayne_Eddins@HUD.gov; telephone (202) 708–2374. This is not a toll-free number. Copies of the proposed forms and other available documents submitted to OMB may be obtained from Mr. Eddins.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposal for the collection of information, as described below, to OMB for review, as required by the Paperwork Reduction Act (44 U.S.C. Chapter 35). The Notice lists the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the information; (3) the OMB approval number, if applicable; (4) the description of the need for the information and its proposed use; (5) the agency form number, if applicable; (6) what members of the public will be affected by the proposal; (7) how frequently information submissions will be required; (8) an estimate of the total number of hours needed to prepare the information submission including number of respondents, frequency of response, and hours of response; (9) whether the proposal is new, an extension, reinstatement, or revision of an information collection requirement; and (10) the name and telephone number of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

This Notice also lists the following information:

Title of Proposal: Previous Participation Certification.

OMB Approval Number: 2502–0118.

Form Numbers; HUD–2530.

Description of the Need for the Information and its Proposed Use: The collection of this information aids in protecting HUD's Multifamily Housing Programs by ensuring participation from responsible individuals and organizations. HUD will use this form to evaluate the feasibility of applicants with respect to their previous track records. Respondents such as owners, managers, consultants, general contractors and nursing home operators, and administrators will be subject to review

Respondents: Individuals or households, Not-for-profit institutions.

Frequency of Submission: Recordkeeping.

Reporting Burden:

Number of respondents	×	Frequency of response	×	Hours per response	=	Burden
4,300		1		0.5		2,150

Total Estimated Burden Hours: 2,150.

Status: Reinstatement, without change.

Authority: Section 3507 of the Paperwork Reduction Act of 1995, 44 U.S.C. 35, as amended.

Dated: January 4, 2001.

Wayne Eddins,

Departmental Reports Management Officer, Office of the Chief Information Officer.

[FR Doc. 01–798 Filed 1–10–01; 8:45 am]

BILLING CODE 4210–01–M

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Advisory Board for Exceptional Children

AGENCY: Bureau of Indian Affairs, Interior.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act, the Bureau of Indian Affairs announces a meeting of the Advisory Board for Exceptional Children in Tempe, Arizona, to discuss the impact of Public Law 105–17, the Individuals with Disabilities Education Act Amendments of 1997, on Indian children with disabilities.

DATES: The Board will meet from 8 a.m. to 4:30 p.m. on Thursday, January 18, 2001; from 8 a.m. to 4:30 p.m. on Friday, January 19, 2001; and from 9 a.m. to 12 p.m. (MST) on Saturday, January 20, 2001

ADDRESSES: The meetings will be held at the Holiday Inn-Tempe/Arizona State University, 915 East Apache Boulevard, Tempe, Arizona 85281. Telephone (480) 968–3451; Fax (480) 968–6262.

Written statements may be submitted to William A. Mehojah, Director, Office of Indian Education Programs, Bureau of Indian Affairs, 1849 C Street, NW., MS–3512, Washington, DC 20240; Telephone (202) 208–6123; Fax (202) 208–3312.

FOR FURTHER INFORMATION CONTACT: Dr. Angelita Felix, Lead Education Specialist, Bureau of Indian Affairs, Office of Indian Education Programs, Division of School Improvement, P.O. Box 1088, Albuquerque, New Mexico 87103; Telephone (505) 248–7529.

SUPPLEMENTARY INFORMATION: The purpose of the Board is to provide advice to the Secretary of the Interior, through the Assistant Secretary—Indian Affairs, on the needs of Indian children with disabilities, as mandated by the Individuals with Disabilities Education Act Amendments of 1997, Public Law 105–17, June 4, 1997.

The agenda for this meeting will cover public comments, approval of minutes, executive committee reports, new business: Approval of by laws, annual report, comprehensive system of a personnel development plan, Office of Special Education Program (OSEP) data collection update, Federal Advisory Committee Act requirements, OSEP improvement plan and Division of School Improvement update. The meeting is open to the public.

The next Board meeting will be held on or about June 14, 2001. Location, date, and time may be obtained from the Division of School Improvement, telephone (505) 248–7527 or 7529; Fax (505) 248–7546.

Dated: December 28, 2000.

Kevin Gover,

Assistant Secretary—Indian Affairs.

[FR Doc. 01–894 Filed 1–10–01; 8:45 am]

BILLING CODE 4310–02–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NV–930–1430–ET]

Termination of Segregation; NV

AGENCY: Bureau of Land Management (BLM), Interior.

ACTION: Notice of termination of segregation.

SUMMARY: This action terminates a portion of the segregation known as the Lincoln Douglas Land Exchange. The land will be opened to the public land laws generally, including the mining and mineral leasing laws.

EFFECTIVE DATE: February 12, 2001.

ADDRESSES: Written comments should be addressed to: Bureau of Land Management, Gene L. Drais, Assistant Field Manager, Nonrenewable Resources, HC 33, Box 33500, Ely, NV 89301–9408.

FOR FURTHER INFORMATION CONTACT: Doris Metcalf, Land Law Examiner, at the above address or telephone (775) 289–1852.

SUPPLEMENTARY INFORMATION: Pursuant to the authority delegated by appendix 1 of Bureau of Land Management Manual 1203 dated November 25, 1998, that portion identified below as being part of the Lincoln Douglas Exchange is hereby terminated in its entirety:

Mount Diablo Meridian, Nevada

T. 6 S., R. 57 E.,
Section 25, NW¼NW¼,
T.5 N., R. 66E.,
Section 15, N½NE¼,
T.5 N., R. 66E.,
Section 26, SW½SW¼,
Section 28, NW¼SE¼.

The area described contains 240 acres in Lincoln County.

The classification made pursuant to the Act of October 21, 1976, amended, and segregated the public land from all other forms of appropriation under the public land laws, including location under the United States mining laws and the mineral leasing laws. The segregation request has been withdrawn, therefore, is no longer needed.

At 10 a.m. on February 12, 2001, the land will be open to the operation of the public land laws and the mineral leasing laws, subject to valid existing rights, existing classifications and withdrawals, and requirements of applicable law. All valid applications received prior to or at 9 a.m. on February 12, 2001, will be considered as simultaneously filed. All other applications received will be considered in order of filing.

At 9 a.m. on February 12, 2001, the lands described above will be opened to location and entry under the United States mining laws, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law. Appropriation of lands under the general mining laws prior to the date and time of restoration is unauthorized. Any such attempted appropriation, including attempted adverse possession under 30 U.S.C. 38, shall vest no rights against the United States. Acts required to establish a location and to initiate a right of possession are governed by State law where not in conflict with Federal law. The Bureau of Land Management will not intervene in disputes between rival locators over possessory rights since Congress has provided for such determinations in local courts.

Dated: December 27, 2000.

Daniel R. Netcher,

Assistant Field Manager, Nonrenewable Resources.

[FR Doc. 01–871 Filed 1–10–01; 8:45 am]

BILLING CODE 4310–HC–M

DEPARTMENT OF THE INTERIOR

Reclamation Bureau

Trinity River Basin Fish and Wildlife Task Force; Meeting

AGENCY: Bureau of Reclamation (Reclamation), Department of the Interior.

ACTION: Notice of public meeting.

SUMMARY: In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463), announcement is made of a meeting of the Trinity River Basin Fish and Wildlife Task Force.

DATES: The meeting will be held on Thursday, February 8, 2001, 9 a.m. to 4 p.m.

ADDRESSES: The meeting will be at the Best Western, 1413 Howe Avenue, Sacramento, California 95825. Telephone 916/922–9833 (FAX 916/922–3384).

FOR FURTHER INFORMATION CONTACT: Mr. Russell P. Smith, Chief, Environmental and Natural Resource Division, Northern California Area Office, 1639 Shasta Dam Boulevard, Shasta Lake, California 96019. Telephone: 530/275–1554 (TDD 530/275–8991).

SUPPLEMENTARY INFORMATION: The Trinity River Basin Fish and Wildlife Task Force will meet to formulate and implement the ongoing Trinity River watershed ecosystem management program for fish and wildlife. This program considers the needs of multiple species and their interactions with physical habitats in restoring the natural function, structure, and species composition of the ecosystem, recognizing that all components are interrelated. Topics will include how future decisions for the Trinity Program will be made and the role of the Task Force.

Dated: January 4, 2001.

Lester A. Snow,

Regional Director.

[FR Doc. 01–816 Filed 1–10–01; 8:45 am]

BILLING CODE 4310–MN–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation and Liability Act

In accordance with the policy of the Department of Justice, notice is hereby given that a proposed consent decree in *United States* v. *American Allied Additivies, Inc., et al.,* Civ. No. 1:00CV1014, was lodged with the United States District Court for the Northern District of Ohio, on December 20, 2000. That action was brought against defendants pursuant to the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) for, *inter alia,* payment of past costs incurred, and future costs to be incurred, by the United States at the American Allied Additives Superfund Site in Cleveland, Ohio. This decree requires seven defendants to pay $23,927.00 in satisfaction of the United States' claims against them for response costs incurred and to be incurred in connection with the site. The United States is continuing litigation and settlement efforts against other defendants in the lawsuit.

The Department of Justice will receive comments relating to the proposed consent decree for a period of 30 days from the date of this publication. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530. All comments should refer to *United States* v.

American Allied Additives, Inc., et al., D. J. Ref. 90–11–2–1318.

The proposed consent decree may be examined at the office of the United States Attorney for the Northern District of Ohio, 1800 Bank One Center, 600 Superior Avenue, Cleveland, Ohio 44114–2600; and at the Region V office of the Environmental Protection Agency, 777 West Jackson Boulevard, Chicago, Illinois 60604–3590. A copy of the proposed consent decree may be obtained in person or by mail from the Department of Justice Consent Decree Library, P.O. Box 7611, Washington, DC 20044–7611. In requesting a copy, plese enclose a check in the amount of $8.25 (25 cents per page reproduction costs) payable to the Consent Decree Library. When requesting a copy, plese refer to *United States* v. *American Allied Additives, Inc., et al.,* D.J. Ref. 90–11–2–1318.

Bruce S. Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–922 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Clean Air Act

Under 28 CFR 50.7, Notice is hereby given that on December 27, 2000, a proposed Consent Decree in *United States and People of the State of Illinois* v. *Archer Daniels Midland Company,* Civil Action No. 00–2338, was lodged with the United States District Court for the Central District of Illinois.

In this action the United States and the People of the State of Illinois seek civil penalties and injunctive relief against Archer Daniels Midland Company (''ADM'') pursuant to Section 113(b) of the Clean Air Act (''CAA''), 42 U.S.C. 7413(b) (1983), amended by, 42 U.S.C. 7413(b) (Supp. 1991), for alleged violations at ADM's Wet Corn Mill Plant located in Decatur, Illinois. Under the settlement, ADM will install venturi scrubbers at fiber feed dryers 5 and 6 at the Wet Corn Mill Plant which will reduce emissions of particulate matter (''PM''). In addition, ADM will pay a civil penalty of $1,463,500, to be equally shared between the United States and the State of Illinois.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Consent Decree. Comments should be addressed to the Assistant Attorney General, environment and Natural Resources Division, U.S. Department of Justice, P.O. Box 7611, Washington, DC 2044–7611, and should refer to *United States and People of the State of Illinois* v. *Archer Daniels Midland Company,* D.J. Ref. 90–5–2–1–2035/1.

The Consent Decree may be examined at the Office of the United States Attorney for the Central District of Illinois, 600 E. Monroe Street, Springfield, Illinois 62705, and at U.S. EPA Region 5, 77 West Jackson Blvd., Chicago, Illinois 60604. A copy of the Consent Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611. In requesting a copy, please enclose a check in the amount of $8.50 (25 cents per page reproduction cost) payable to the Consent Decree Library.

Bruce Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–925 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation and Liability Act

In accordance with Department of Justice policy codified at 28 CFR 50.7 and section 122 of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (''CERCLA''), 42 U.S.C. 9622, notice is hereby given that on December 20, 2000, a proposed consent decree in *United States* v. *Dayton Power & Light Co., et al.*, No. C–3–98–451, was lodged with the United States District Court for the Southern District of Ohio. The consent decree represents a settlement of claims against Robert B. Snyder and the Robert L. Snyder Trust (collectively, ''Settling Defendants'') under CERCLA § 107(a), 42 U.S.C. § 9607(a), for the recovery of response costs incurred or to be incurred by the United States in connection with the Sanitary Landfill (IWD) Superfund Site (''Site'') in Moraine, Ohio. Each of the Settling Defendants is an owner and operator of the Site, which was operated as a licensed landfill by Sanitary Landfill Company and its successor corporations from 1971 to 1980. The U.S. Environmental Protection Agency incurred costs of approximately $1.2 million in responding to the release or threatened release of hazardous substances at the Site. Under the terms of the consent decree, the Settling Defendants agree to pay to the United States $10,000 in response costs within thirty (30) days of entry of the consent decree. In consideration for this payment, the Settling Defendants will receive a covenant not to sue for Site response costs and contribution protection. The settlement is based on the Settling Defendants' limited ability to pay.

For a period of thirty (30) days from the date of this publication, the Department of Justice will receive comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, U.S. Department of Justice, 950 Pennsylvania Avenue, NW, Washington, DC 20530, and should refer to *United States* v. *Dayton Power & Light Co., et al.,* Civil Action No. C–3–98–451; D.J. Ref. No. 90–11–2–1113A.

The consent decree may be examined at the Office of the United States Attorney, 602 Federal Building, 200 W. 2nd Street, Dayton, Ohio 45402, and at the U.S. Environmental Protection Agency, Region 5, 77 West Jackson Boulevard, Chicago, Illinois 60604. A copy of the consent decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611. In requesting a copy, please enclose a check in the amount of $5.25 (21 pages at 25 cents per page reproduction cost).

Bruce S. Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–918 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Clean Air Act, Clean Water Act, RCRA, and EPCRA

Under 28 CFR 50.7, notice is hereby given that on December 22, 2000, a proposed Complaint and Consent Decree in *United States* v. *Koch Petroleum Group, L.P.,* Civil Action No. 00–2756–PAM–SRN, was lodged with the United States District Court for the District of Minnesota.

In this action the United States sought civil penalties and injunctive relief against Koch Petroleum Group, L.P., (''Koch'') pursuant to section 113(b) of the Clean Air Act (''CAA''), 42 U.S.C. 7413(b) (1983), *amended by,* 42 U.S.C. 7413(b) (Supp. 1991), the Resource Conservation and Recovery Act, (''RCRA''), 42 U.S.C. 6901 *et seq.*; the Emergency Planning and Community Right to Know Act (''EPCRA''), 42 U.S.C. 11004(a); and the Clean Water

Act (''CWA''), 33 U.S.C. 1321(b)(3) and (j) for alleged violations at Koch's 3 refineries: Pine Bend, Minnesota, and the East and West refineries in Corpus Christi, Texas. Under the settlement, Koch will implement innovative pollution control technologies to greatly reduce emissions of nitrogen oxides (''NO_X'') and sulfur dioxide (''SO2'') from refinery process units and adopt facility-wide enhanced monitoring and fugitive emission control programs. In addition, Koch will pay a civil penalty of $4.5 million, $3.5 million of which is for settlement of the RCRA claims. The state of Minnesota will join in this settlement as a signatory to the Consent Decree.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Consent Decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, PO Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Koch Petroleum Group, L.P.,* D.J. Ref. 90–5–2–1–07110.

The Consent Decree may be examined at the Office of the United States Attorney, 234 United States Courthouse, 110 South Fourth Street, Minneapolis, Minnesota 55401 and at U.S. EPA Region 5, 77 West Jackson Blvd., Chicago, Illinois 60604. A copy of the Consent Decree may also be obtained by mail from the Consent Decree Library, PO Box 7611, U.S. Department of Justice, Washington, DC 20044–7611. In requesting a copy, please enclose a check in the amount of $39.50 (25 cents per page reproduction cost) payable to the Consent Decree Library.

Bruce Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–923 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree for Natural Resource Damages Under CERCLA

Notice is hereby given that on December 28, 2000, a proposed consent decree in *United States* v. *Lone Mountain Processing, Inc.,* Civil Action No. 2:00CV00200, was lodged with the United States District Court for the Western District of Virginia.

The consent decree settles claims against Lone Mountain Processing, Inc., under section 107(f) of the Comprehensive Environmental Response, Compensation and Liability Act, as amended, 42 U.S.C. 9607. The releases that give rise to the claims are from coal slurry spills from a coal processing plant owned by Lone Mountain in Lee County, Virginia, and took place on or about August 9, 1996, and October 24, 1996. The releases caused injury to natural resources in the Powell River Wasteshed and injured species and habitat for which the Department of Interior has trusteeship. The Consent Decree settles the natural resource damage claim in exchange for a payment by Lone Mountain of $2,450,000.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the consent decrees. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer to *United States* v. *Lone Mountain Processing, Inc.*, D.J. Ref. 90–5–1–1–06615.

The consent decree may be obtained by mail from the Department of Justice Consent Decree Library, PO Box 7611, Washington, DC 20044–7611. In requesting copies from the Consent Decree Library, please enclose a check in the amount of $3.50 for the consent decree payable to the Consent Decree Library.

Bruce S. Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–921 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Clean Water Act

In accordance with the Departmental policy, 28 U.S.C. 50.7, notice is hereby given that a proposed Consent Decree in *United States of America and State of Louisiana* v. *City of Mandeville, Louisiana,* Civil Action No. 00–366 ''R'' (5) was lodged on December 12, 2000, with the United States District Court for the Eastern District of Louisiana.

The Consent Decree settles an action brought under sections 309(b) of the Clean Water Act (''CWA''), 33 U.S.C. 1319(b). The Consent Decree requires the City of Mandeville, Louisiana (''Mandeville'') to pay a civil penalty to the United States in the amount of $56,500, requires injunctive relief to bring Mandeville into compliance with the Clean Water Act, and provides for interim limits for the discharge of ammonia-nitrogen, biochemical oxygen demand (''BOD''), and total suspended solids (''TSS'') from Mandeville's public sewage treatment plant.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed Consent Decree. Comments should be addressed to the Assistant Attorney General for the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer to *United States of America and State of Louisiana* v. *City of Mandeville, Louisiana,* (E.D. La.), DOJ Ref. #90–5–1–1–06613.

The proposed Consent Decree may be examined at the office of the United States Attorney, Eastern District of Louisiana, Hale Boggs Federal Building, 501 Magazine Street, Second Floor, New Orleans, LA 70130, the U.S. Environmental Protection Agency, Region VI, 1445 Ross Avenue, Dallas, Texas 75202; and at the Consent Decree Library, 1120 G Street, NW., Third Floor, Washington, DC 20005, (202) 624–0892. A copy of the proposed Consent Decree may be obtained in person or by mail from the Consent Decree Library, P.O. Box 7611, Washington, DC 20044–7611. When requesting a copy please refer to *United States of America and State of Louisiana* v. *City of Mandeville, Louisiana,* (E.D. La.), DOJ Ref. #90–5–1–1–06613 enclose a check in the amount of $7.00 (25 cents per page reproduction costs), payable to the ''Consent Decree Library.''

Catherine McCabe,

Deputy Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–924 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation and Liability Act

In accordance with 28 CFR 50.7 and section 122 of the Comprehensive Response, Compensation and Liability Act (''CERCLA''), 42 U.S.C. 9622, the Department of Justice gives notice that a proposed consent decree in *United States* v. *Mark IV Industries, Inc. et al.,* No. 1:00CV918 (W.D. Mich.), was lodged with the United States District Court for the Western District of Michigan on December 18, 2000, pertaining to the implementation of the United States Environmental Protection

Agency's selected remedial action for the Electro-Voice Superfund Site (''EV Site''), Buchanan, Berrien County, Michigan.

Under the proposed consent decree, Mark IV Industries, Inc. will implement U.S. EPA's selected remedy for operable unit 2 (''OU2'') at the Site, and pay U.S. EPA's oversight costs. The Consent Decree includes a covenant not to sue by the United States under sections 106 and 107 of the Comprehensive Environmental Response, Compensation and Liability Act, 42 U.S.C. 9601 *et seq.* (''CERCLA''), and section 7003 of the Resource Conservation and Liability Act (''RCRA''), 42 U.S.C. 6973.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resource Division, United States Department of Justice, Washington, DC 20530, and should refer to *United States* v. *Mark IV Industries, Inc. et al.,* No. 1:00CV918 (W.D. Mich.), and DOJ Reference No. 90–11–2–07050. Commentors may request an opportunity for a public meeting in the affected area, in accordance with RCRA section 7003(d), 42 U.S.C. 6973(d).

The proposed consent decree may be examined at: (1) The Office of the United States Attorney for the Western District of Michigan, 330 Ionia, NW., Grand Rapids, Michigan 49503 (616) 456–2404; and (2) the United States Environmental Protection Agency (Region 5), 77 West Jackson Boulevard, Chicago, Illinois 60604–3590 (contact Kris Vezner (312–886–6827)) a copy of the proposed consent decree may be obtained by mail from the Consent Decree Library, PO Box 7611, Washington, DC 20044. In requesting a copy, please refer to the referenced case and DOJ Reference Number and enclose a check in the amount of $18.25 for the consent decree only (73 pages at 25 cents per page reproduction costs), or $75.75 for the consent decree and all appendices (303 pages), made payable to the consent Decree Library.

Bruce S. Gelber,

Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–920 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation and Liability Act

In accordance with the policy of the Department of Justice, notice is hereby given that a proposed consent decree in *United States* v. *Michigan Consolidated Gas Co.,* Civ. No. 01–70007, was lodged with the United States District Court for the Eastern District of Michigan, on January 2, 2001. That action was brought against defendant pursuant to the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA) for payment of past costs incurred, and future costs to be incurred, by the United States at the Lower Ecorse Creek Superfund Site in Wyandotte, Michigan. This decree requires the defendant to pay $230,000.00 in satisfaction of the United States' claims against it for response costs incurred and to be incurred in connection with the site.

The Department of Justice will receive comments relating to the proposed consent decree for a period of 30 days from the date of this publication. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530. All comments should refer to *United States* v. *Michigan Consolidated Gas Co.,* D.J. Ref. 90–11–3–1744.

The proposed consent decree may be examined at the office of the United States Attorney for the Eastern District of Michigan, 211 W. Fort Street, Suite 2001, Detroit, MI 48226–3211; and at the Region V office of the Environmental Protection Agency, 77 West Jackson Boulevard, Chicago, Illinois 60604–3590. A copy of the proposed consent decree may be obtained in person or by mail from the Department of Justice Consent Decree Library, PO Box 7611, Washington, DC 20044–7611. In requesting a copy, please enclose a check in the amount of $4.25 (25 cents per page reproduction costs) payable to the Consent Decree Library. When requesting a copy, please refer to *United States* v. *Michigan Consolidated Gas Co.,* D.J. Ref. 90–11–3–1744.

Bruce S. Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–926 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Clean Air Act, Clean Water Act, RCRA, and EPCRA

Under 28 CFR 50.7, notice is hereby given that on December 19, 2000, a proposed Complaint and Consent Decree in *United States* v. *Nucor Corporation*, Civil Action No. 4–00:3945–24, was lodged with the United States District Court for the District of South Carolina.

This is a national, multi-facility, multi-media enforcement action against Nucor Corporation (''Nucor''), a major manufacturer of steel and steel products. This action is brought pursuant to section 113(b) of the Clean Air Act (''CAA''), 42 U.S.C. 7413(b) (1983), *amended by* 42 U.S.C. 7413(b) (Supp. 1991); the Resource Conservation and Recovery Act, (''RCRA''), 42 U.S. 6901 *et seq.*; the Emergency Planning and Community Right to Know Act (''EPCRA''), 42 U.S.C. 11004(a); and the Clean Water Act (''CWA''), 33 U.S.C. 1251 *et seq.* This settlement involves 8 steel mini-mills and 6 steel fabrication facilities located in Alabama, Arkansas, Indiana, Nebraska, South Carolina, Texas, and Utah, in EPA Regions 4, 5, 6, 7, and 8. The Complaint alleges that Nucor violated the Prevention of Significant Deterioration (''PSD'') and New Source Performance Standard (''NSPS'') provisions of the Clean Air Act and that K061 dust, a waste product from the electric arc furnaces (''EAFs'') and a RCRA listed hazardous waste, was disposed of illegally at the facilities and contributed to National Pollution Discharge Elimination System (''NPDES'') permit and Industrial Storm Water violations of the Clean Water Act. In addition, the Complaint alleges that K061 dust has contaminated soil and groundwater at Nucor's steel mills.

The proposed settlement will require Nucor to pilot air pollution control technologies for control of NO_x emissions from its EAFs and reheat furnaces. Nucor will also conduct sampling of ground water and soils at all facilities, identify areas of contamination and perform corrective action in accordance with an EPA-approved RCRA statement of work for each facility. in addition, Nucor will implement enhancements to its management of K061, and its process and storm water to ensure continued compliance with CWA requirements. Nucor will also pay a civil penalty of $9 million, and spend $4 million on Supplemental Environmental Projects. The states of Arkansas, Nebraska, and Utah are joining in this settlement as

Plaintiff-Interveners and will share in the civil penalties. The state of South Carolina will also be a signatory to the Consent Decree under a provision of state law that authorizes its participation, however, South Carolina will not file a separate enforcement action and will not share in the civil penalties.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Consent Decree. Comments should be addressed to the Assistant Attorney General, Environmental and Natural Resources Division, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States* v. *Nucor Corporation*, D.J. Ref. 90–5–2–1–06407/1.

The Consent Decree may be examined at the Office of the United States Attorney, 1st Union Building, 1441 Main Street, Suite 500, Columbia, South Carolina 29201 and at U.S. EPA, Multimedia Enforcement Division, Office of Regulatory Enforcement, 1200 Pennsylvania Ave., NW., Washington, DC 20460. A copy of the Consent Decree may also be obtained by mail from the Consent Decree Library, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611. In requesting a copy, please enclose a check in the amount of $60.25 (25 cents per page reproduction cost) payable to the Consent Decree Library.

Bruce Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–919 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Clean Air Act

In accordance with Departmental policy, 28 CFR 50.7, notice is hereby given that on December 28, 2000, a proposed Consent Decree in *United States* v. *Puerto Rico Medical Services Administration*, Civil Action No. 00–2620, was lodged with the United States District Court for the District of Puerto Rico. The proposed Consent Decree will resolve the United States' claims under the Clean Air Act, 42 U.S.C. 7401 *et seq.* on behalf of the U.S. Environmental Protection Agency against defendant Puerto Rico Medical Services Administration (''PRMSA'').

Pursuant to the Consent Decree, PRMSA will pay a civil penalty of $65,000. In addition, PRMSA agrees to comply with the New Source Performance Standards (''NSPS'') with respect to two boiler affected facilities, to assure that relevant Puerto Rico Environmental Quality Board (''EQB'') Air permits state that the boilers are subject to Subpart Dc of the NSPS, to combust only low sulfur distillate fuel in both of the boilers, and to conduct a performance test for opacity with respect to one of its boilers. Finally, PRMSA has agreed to finance the performance of a Supplemental Environmental Project at a cost of $100,000.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the proposed Consent Decree. Any comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, P.O. Box 7611, Ben Franklin Station, Washington, DC 20044, and should refer to *United States* v. *Puerto Rico Medical Services Administration*, Civil Action No. 00–2620, D.J. Ref. 90–5–2–1–06109.

The proposed Consent Decree may be examined at the Office of the United States Attorney, District of Puerto Rico, Federal Office Building, Carlos E. Chardon Avenue, Hato Rey, Puerto Rico 00918, and at Region II, United States Environmental Protection Agency, 290 Broadway, New York, New York 10007. A copy of the proposed Consent Decree may be obtained by mail from the Department of Justice Consent Decree Library, P.O. Box 7611, Ben Franklin Station, Washington, DC 20044. In requesting a copy, please enclose a check (there is a 25 cent per page reproduction cost) in the amount of $9.00 payable to the Consent Decree Library.

Bruce S. Gelber,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 01–927 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act

Notice is hereby given that a consent decree in *United States of America* v. *Sonoco Products Company,* Civil Action No. 00–CV–5802 (E.D. Pa.) was lodged with the court on November 15, 2000.

The proposed consent decree resolves the claims of the United States of America against defendant Sonoco Products Company, under section 107 of the Comprehensive Environmental Response, Compensation and Liability Act, as amended (''CERCLA''), 42 U.S.C. 9607, for past response costs at the Struble Trail Superfund Site located at East Caln Township, in Chester County, Pennsylvania (the ''Site''), which was owned and operated by Downingtown Paper Company, the predecessor by merger to the Defendant, Sonoco Products Company. The decree obligates the Settling Defendant to reimburse $36,936.98 of the United States' past response costs.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, P.O. Box 7611, U.S. Department of Justice, Washington, DC 20044–7611, and should refer to *United States of America* v. *Sonoco Products Company,* DOJ Ref. #90–11–3–07203.

The proposed consent decree may be examined and copied at the Office of the United States Attorney, 615 Chestnut Street, Suite 1250, Philadelphia, PA 19106; or at the Region III Office of the Environmental Protection Agency, c/o Thomas A. Cinti, Assistant Regional Counsel, 1650 Arch Street, Philadelphia, PA 19103. A copy of the proposed consent decree may be obtained by mail from the Consent Decree Library, P.O. Box No. 7611, Washington DC 20044. In requesting a copy, please refer to the referenced case and enclose a check in the amount of $5.25 (25 cents per page reproduction costs), payable to the Consent Decree Library. A copy of the exhibits to the decree may be obtained from the same source for an additional charge.

Nuriye C. Uygur,

Assistant U.S. Attorney's Office for the Eastern District of Pennsylvania.

[FR Doc. 01–935 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Researach and Production Act of 1993—4C Founders

Notice is hereby given that, on November 2, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), 4C Founders has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) the identities

of the parties and (2) the nature and objectives of the venture. The notifications were filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to Section 6(b) of the Act, the identities of the parties are Intel Corporation, Santa Clara, CA; International Business Machines Corporation, Armonk, NY; Matsushita Electric Industrial Co., Ltd., Osaka, JAPAN; and Toshiba Corporation, Tokyo, JAPAN. The nature and objectives of the venture are to develop interoperable specifications or the protection of copyrighted digital audio and video content from unauthorized interception and copying; and to promote adoption of the specifications by (i) licensing them on reasonable and nondiscriminatory terms. (ii) providing technical support to adopters, content providers, and other who implement the specifications; (iii) generating and supplying keys for encryption and decryption of the digital content so protected; (iv) providing a means to receive comments and feedback from parties implementing the specifications; and (v) consulting with standards bodies, and others engaged in related specifications efforts, and potential users of the specifications. The 4C Founders' specifications will include information directing specific implementations only as necessary to enable, promote, and improve protection of digital audio and video content; to preserve the security of the protection method; and to promote interoperability of products (including information technology and consumers electronic devices), media which implement the specifications, and the means for distributing content so protected.

In furtherance of the purposes stated above, the 4C Founders may, among other things, engage in theoretical analysis; experimentation; systematic study; research; development; testing; extension of investigative findings or theories of a scientific or technical nature into practical application for experimental and demonstration purposes; collection, exchange and analysis of research or production information; enter into agreements to carry out the objectives of the Founders; establish and operate facilities for conducting such venture conduct such venture on a protected and proprietary basis; prosecute applications for patents and grant licenses for the results of such venture; and any combination of these activities.

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 01–933 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—Advanced Technology Proposal No. 00–00–4061

Notice is hereby given that, on July 18, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), the parties to Advanced Technology Proposal No. 00–00–4061 have filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing (1) the identities of the parties and (2) the nature and objectives of the venture. The notifications were filed for the purpose of invoking the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Pursuant to Section 6(b) of the Act, the identities of the parties are Caterpillar Inc., Peoria, IL; United Technologies Corporation, acting through its unincorporated operating unit, United Technologies Research Center, East Hartford, CT; and J.A. Woollam Co., Inc., Lincoln, NE. The nature and objectives of the venture are to develop the technology tools needed to implement nanostructured coatings for competitive advantage.

The activities of this joint venture will be partially funded by an award from the Advanced Technology Program, National Institute of Standards and Technology, Department of Commerce.

Constance K. Robinson,

Director of Operations Antitrust Division.

[FR Doc. 01–931 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—Digital Imaging Group

Notice is hereby given that, on November 3, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), Digital Imaging Group has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing changes in its membership status. The notifications were filed for the purpose of extending the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Specifically, Shutterfly.com, Redwood City, CA; Kowa Company, Ltd., San Jose, CA; Luna Imaging, Inc., Venice CA; BroadCloud Communications, Inc., Austin, TX; Interactive Multimedia Production GmbH, Freidrichshafen, GERMANY; Cobion GmbH, Wassel, GERMANY; AND Zoomify, Inc., Santa Cruz, CA have been dropped as parties to this venture.

No other changes have been made in either the membership or planned activity of the group research project. Membership in this group research project remains open, and Digital Imaging Group intends to file additional written notification disclosing all changes in membership.

On September 25, 1997, Digital Imaging Group filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the **Federal Register** pursuant to Section 6(b) of the Act on November 10, 1997 (62 FR 60530).

The last notification was filed with the Department on August 2, 2000. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on September 13, 2000 (65 FR 55282).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 01–929 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—Enterprise Computer Telephony Forum

Notice is hereby given that, on October 10, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), Enterprise Computer Telephone Forum (''ECTF'') has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing changes in its membership status. The notifications were filed for the purpose of extending the Act's provisions limiting the

recovery of antitrust plaintiffs to actual damages under specified circumstances. Specifically, StarGen, Inc., Marlborough, MA; ESI, Plano, TX; Karel Elektronik S.A., Ankara, TURKEY; Integrated Device Technology, Inc., Santa Clara, CA; Call Sciences, Inc., Edison, NJ; ADICTI Corp., Taichung, TAIWAN; and Inovax Engenharia de Sistemas Ltd., Rio de Janeiro, BRAZIL have been added as parties to this venture. Also, StarBridge Technologies, Inc., Marlborough, MA has been dropped as a party to this venture.

No other changes have been made in either the membership or planned activity of the group research project. Membership in this group research project remains open, and ECTF intends to file additional written notifications disclosing all changes in membership.

On February 20, 1996, ECTF filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the **Federal Register** pursuant to section 6(b) of the Act on May 13, 1996, (61 FR 22074).

The last notification was filed with the Department on August 2, 2000. A notice was published in the **Federal Register** pursuant to section 6(b) of the Act on October 26, 2000 (65 FR 64236).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 01–932 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993—IOPS.ORG Project

Notice is hereby given that, on January 27, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), the Corporation for National Research Initiatives (''CNRI'') has filed written notifications simultaneously on behalf of a Cooperative Project between CNRI and participants known as the IOPS.ORG Project (''IOPS'') with the Attorney General and the Federal Trade Commission disclosing changes in its membership status. The notifications were filed for the purpose of extending the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Specifically, AT&T Global Networking Services, Basking Ridge, NJ; Broadwing Communications Services, Inc., Austin, TX; Cable & Wireless, Washington, DC; Conxion, Santa Clara, CA; and Qwest, Denver, CO have been added as Primary Members of this project. ANS CO+RE Systems, Inc., Elmsford, NY; BBN Corporation, Cambridge, MA; MCI Telecommunications, Washington, DC; PSINet, Inc., Herndon, VA; and UUNET Technologies, Fairfax, VA have been discontinued as Primary Members of this project.

The following companies have changed their names: AT&T Corporation, Basking Ridge, NJ is now AT&T Worldnet, Basking Ridge, NJ; GTE Intelligent Network Systems, Inc., Irving TX is now GTE Internetworking, Irving, TX; NETCOM On-Line Communications Services, Inc., San Jose, CA is now ICG Communications, Englewood, CO; and Sprint Communications Company, LLP, Kansas City, MO is now Sprint Internet Service Center, Kansas City, MO.

No other changes have been made in either the membership or planned activity of the group research project. Membership in this group research project remains open, and CNRI intends to file additional written notifications disclosing all changes in membership.

On July 2, 1997, CNRI filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the **Federal Register** pursuant to section 6(b) of the Act on October 6, 1997 (62 FR 52152).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 01–930 Filed 1–10–01 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF JUSTICE

Antitrust Division

Notice Pursuant to the National Cooperative Research and Production Act of 1993; Mobile Wireless Internet Forum

Notice is hereby given that, on November 13, 2000, pursuant to section 6(a) of the National Cooperative Research and Production Act of 1993, 15 U.S.C. 4301 *et seq.* (''the Act''), Mobile Wireless Internet Forum has filed written notifications simultaneously with the Attorney General and the Federal Trade Commission disclosing changes in its membership status. The notifications were filed for the purpose of extending the Act's provisions limiting the recovery of antitrust plaintiffs to actual damages under specified circumstances. Specifically, Adaptive Telecom, Campbell, CA; Airvana, Waltham, MA; Alteon WebSystems, San Jose, CA; Avian Communications, Marlborough, MA; BT Wireless, Martlesham Health, Ipswich, United Kingdom; CoSine Communications, Redwood City, CA; DoCoMo Communications Labs, San Jose, CA; Flash Networks, Holmdel, NJ; Halfdome Systems, Sunnyvale, CA; Hitachi, Santa Clara, CA; LG Telecom, San Diego, CA; Libertel, Maastricht, Limburg, The Netherlands; Livemind, Inc., San Francisco, CA; Matsushita Communications Industrial, Yokohama, Japan; Megisto Systems, Germantown, MD; Mitsubishi Electric Corporation, Kamakura, Kanagawa, Japan; Morphics Technology, Campbell, CA; Nettle Network Technologies, Arlington, VA; NuLink, Wilmington, CA; phone.com, Temple Terrace, FL; Redback News, Sunnyvale, CA; Sony, Tokyo, Japan; T-Mobil, Bonn, Germany; Telcom New Zealand, Wellington, New Zealand; Teledesic, Bellevue, WA; Trillium Digital Systems, Los Angeles, CA; UUNET a Worldcom Company, Purchase, NY; Verizon Wireless, Walnut Creek, CA; Water Cove Networks, Inc., Burlington, MA; White.Cell, Inc., Rosh-Ha'ayin, Israel; Wind, Rome, Italy; and Wysdom, Richmond Hill, Ontario, Canada have been added as parties to this venture.

No other changes have been made in either the membership or planned activity of the group research project. Membership in this group research project remains open, and Mobile Wireless Internet Forum intends to file additional written notification disclosing all changes in membership.

On May 25, 2000, Mobile Wireless Internet Forum filed its original notification pursuant to section 6(a) of the Act. The Department of Justice published a notice in the **Federal Register** pursuant to section 6(b) of the Act on August 11, 2000 (65 FR 49264).

Constance K. Robinson,

Director of Operations, Antitrust Division.

[FR Doc. 01–934 Filed 1–10–01; 8:45 am]

BILLING CODE 4410–11–M

DEPARTMENT OF LABOR

Employment and Training Administration

Notice of Determinations Regarding Eligibility To Apply for Worker Adjustment Assistance and NAFTA Transitional Assistance

In accordance with section 223 of the Trade Act of 1974, as amended, the Department of Labor herein presents summaries of determinations regarding eligibility to apply for trade adjustment assistance for workers (TA–W) issued during the period of December, 2000 and January, 2001.

In order for an affirmative determination to be made and a certification of eligibility to apply for worker adjustment assistance to be issued, each of the group eligibility requirements of section 222 of the Act must be met.

(1) That a significant number of proportion of the workers in the workers' firm, or an appropriate subdivision thereof, have become totally or partially separated,

(2) That sales or production, or both, of the firm or subdivision have decreased absolutely, and

(3) That increases of imports of articles like or directly competitive with articles produced by the firm or appropriate subdivision have contributed importantly to the separations, or threat thereof, and to the Absolute decline in sales or production.

Negative Determinations for Worker Adjustment Assistance

In each of the following cases the investigation revealed that criterion (3) has not been met. A survey of customers indicate that increased imports did not contribute importantly to work separations at the firm.

TA–W–38,153; Agco Corp., Coldwater, OH
TA–W–37,904; Fieldcrest Cannon, Inc., Pillowtex, Plant #7, Salisbury, NC
TA–W–38,292; Carolina Mills, Plant #25, St. Pauls, NC
TA–W–38,182; Cox Target Media Sales, Inc., Washington, NC;
TA–W–38–101 & A; Bonney Forge Corp., Allentown , PA, and Mt. Union, PA
TA–W–37,941; Royal Oak Enterprises, Inc., Licking, MO
TA–W–38,162; Excel Finishing, Inc., Old Fort, NC
TA–W–38,093; Kezar Falls Woolen Co., A Div. of Robinson Manufacturing Co., Parsonsfield, ME
TA–W–38,169 & A; Quality Veneer and Lumber, Hanel Lumber Div., Hold River, OR and Odell, OR

In the following cases, the investigation revealed that the criteria for eligibility have not been met for the reasons specified.

TA–W–38,343; United Steelworkers of America, Local 2176, Gadsden, AL
TA–W–38,203; Anchor Glass Container, Dayville, CT
TA–W–38,199; Uniscribe Professional Services, Inc., Wheeling, WV
TA–W–38,313, Winn-Dixie Raleigh, Inc., Garden City, SC
TA–W–38,205; Crater Lake Potato Distributors, Klamath Falls, OR

The workers firm does not produce an article as required for certification under Section 222 of the Trade Act of 1974.

TA–W–38,193; Contract Apparel, Inc., El Paso, TX
TA–W–38,186; Nine West Distribution Center, Cincinnati, OH
TA–W–38,267; A and B Component Parts Shubuta, MS
TA–W–38,052; Pulaski Furniture, Plant #2, Martinsville, VA
TA–W–38,298; JN Oil and Gas, Inc., Headquartered in Billings, MT and Operating in the Following States: A; MT, B; TX, C; ND, D; WY, E; OK, F; KS
TA–W–38,026; Holcroft, LLC, Livonia, MI
TA–W–38,227; Vulcan Materials, Attalla, AL
TA–W–38,181; PPG Industries, Inc., Springdale, PA
TA–W–38,254; Parker Hannifin Corp., Process Filtration Div., Lebanon, IN
TA–W–38,151; Elliott Turbomachinery, Inc., Jeannette, PA
TA–W–38,138; Raytheon Corp., Lewisville, TX

Increased imports did not contribute importantly to workers separations at the firm.

TA–W–38,071; Molteck Power Systems, Gainesville, FL

The investigation revealed that criteria (2) has not been met. Sales or production did not decline during the relevant period as required for certification.

TA–W–38,253; Intercontinental Branded Apparel, Ellwood Ave., Buffalo, NY
TA–W–38,230; Heraeus Sensor Nite Co., Ellwood City, PA

The investigation revealed that criteria (1) has not been met. A significant number or proportion of the workers did not become totally or partially separated from employment as required for certification.

Affirmative Determinations for Worker Adjustment Assistance

The following certifications have been issued; the date following the company name and location of each determination references the impact date for all workers of such determination.

TA–W–38,165; L and L Manufacturing Co., Inc., L and L Factory, Los Angeles, CA; September 19, 1999.
TA–W–38,116; S. I. Cutting Service, Opalocka, FL: September 13, 1999.
TA–W–38,015; Boyt Brands, Bedford, IA: August 11, 1999.
TA–W–38,224; Handy Girl, LLC, Deer Park, MD: March 7, 2000.
TA–W–38,246; Jakel, Inc., East Prairie, MO: October 13, 1999.
TA–W–38,210; Chilton Toys, Div. of Strombecker Corp., Seymour, WI: September 26, 1999.
TA–W–38,139; Lyall Alabama, Ardmore, AL: September 6, 1999.
TA–W–38,351; Tyco Electronics, Sanford, ME: November 7, 1999.
TA–W–38,333; Smith and Wesson, Springfield, MA: November 2, 1999.
TA–W–38,250; Designer Hearths, Inc., Missoula, MT: October 17, 1999.
TA–W–38,259; Precision Interconnect Medical Cable Div., Waupin, WI: October 17, 1999.
TA–W–38,090; Waynesboro Apparel, Inc., Waynesboro, TN: August 31, 1999.
TA–W–38,236; PACE Industries, Puget Div., Inc., Fircrest, WA: October 6, 1999.
TA–W–38,226; Stimson Lumber co., Bonner, MT: October 4, 1999.
TA–W–38,975; U.S. Textile Corp., Newland, NC: July 25, 1999.
TA–W–38,092; Xerox Colorgraphx Systems, San Jose, CA: September 1, 1999.
TA–W–38,335; Victor Electric Wire and Cable Corp., Coventry, RI: November 1, 1999.
TA–W–38,896; Knowles Electronics, Inc., Hearing Aid Component Unit, Itasca, IL and Elgin, IL: July 5, 1999.
TA–W–38,152; Montgomery Hosiery Mill, Inc., Star, NC: September 18, 1999.
TA–W–38,172; Maxxim Medical, Los Gator, CA: September 15, 1999.
TA–W–38,180; Northern Cap Manufacturing Co., Little Falls, MN: September 25, 1999.
TA–W–38,251; Technical Ruber and Plastic Corp., Clifton, NJ: October 10, 1999.
TA–W–38,433; Full Line Distributors, Inc., d/b/a L.A.T. Sportswear, Canton, GA: December 6, 1999.
TA–W–38,361; Don Shapiro Industries, Inc., Action West Div., El Paso, TX: May 13, 2000.
TA–W–38,224; Utica Cutlery Co., Utica Stainless Div., Utica, NY: October 4, 1999.
TA–W–38,367; Key Industries, Inc., Erin, TN: November 14, 1999.
TA–W–38,436; United States Leather, Lackawanna Leather, Including Leased Workers of Snelling Personnel Services, El Paso, TX: December 1, 1999.
TA–W–38,200; M. Fine and Sons Manufacturing Co., Inc., Loretto, TN: September 17, 1999.
TA–W–38,003; Parker Seal Co., Berea, KY: August 28, 1999.
TA–W–38,318; Pyramid Mountain Lumber, Inc., Seeley Lake, MT: October 30, 1999.
TA–W–38,225; Alcoa Fujikura Ltd., Heavy Truck and Industrial Div., Shelbyville, KY: October 6, 1999.
TA–W–38,303; CMI Industries, Inc., Geneva, AL: October 27, 1999.

TA–W–38,278; Breli Originals, Inc., New York, New York: October 23, 1999.
TA–W–38,232; Carolina Shoe Co., Morganton, NC: October 4, 1999.
TA–W–38,457; Copper Range Co., White Pine, MI: September 27, 1997.
TA–W–38,187; Talon, Inc., Commerce, CA: September 25, 1999.
TA–W–38,359; Johns Manville International, Inc., Corona, CA: November 8, 1999.
TA–W–38,083 & A; Allegheny Ludlum Corp., Jessop Plate Mill, Jessop O & T, Washington Flat Roll (Formerly Washington Steel Corp.), Washington, PA and Houston, PA: August 30, 1999.
TA–W–38,256; Wundies-Santtony Wear, Seaming and Shipping Dept., Rockingham, NC: October 17, 1999.
TA–W–38,312; R & S Manufacturing, Columbia, PA: November 13, 1999.
TA–W–38,403; ICI Explosives USA, Inc., Ammonium Nitrate Div., Joplin, MO: November 17, 1999.
TA–W–38,047; Rockwell Automation, Sheet Metal Fabrication Dept., Euclid Plant, Euclid, OH: August 25, 1999.
TA–W–38,222; Whatman, Inc., Clifton, NJ: October 2, 1999.
TA–W–38,126 & A; Eastland Shoe Manufacturing Corp., Lisbon Falls, ME and Freeport, ME: November 17, 2000.
TA–W–38,184; JB Sportswear, Union, MS: October 10, 1999.
TA–W–38,371; Sasib Food and Beverage Machinery, Sasib Packaging North America, Depere, WI: November 14, 1999.

Also, pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance hereinafter called (NAFTA–TAA) and in accordance with section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act as amended, the Department of Labor presents summaries of determinations regarding eligibility to apply for NAFTA–TAA issued during the month of December, 2000 and January 2001.

In order for an affirmative determination to be made and a certification of eligibility to apply for NAFTA–TAA the following group eligibility requirements of Section 250 of the Trade Act must be met:

(1) That a significant number of proportion of the workers in the workers' firm, or an appropriate subdivision thereof, (including workers in any agricultural firm or appropriate subdivision thereof) have become totally or partially separated from employment and either—

(2) That sales or production, or both, of such firm or subdivision have decreased absolutely,

(3) That imports from Mexico or Canada of articles like or directly competitive with articles produced by such firm or subdivision have increased, and that the increases imports contributed importantly to such workers' separations or threat of separation and to the decline in sales or production of such firm or subdivision; or

(4) That there has been a shift in production by such workers' firm or subdivision to Mexico or Canada of articles like or directly competitive with articles which are produced by the firm or subdivision.

Negative Determinations NAFTA–TAA

In each of the following cases the investigation revealed that criteria (3) and (4) were not met. Imports from Canada or Mexico did not contribute importantly to workers' separations. There was no shift in production from the subject firm to Canada or Mexico during the relevant period.

NAFTA–TAA–04297; Aavid Thermalloy, Santa Ana Plant, Santa Ana, CA
NAFTA–TAA–04029 & A; Knowles Electronics, Inc., Hearing Aid Component Unit Itasca, IL and Elgin, IL
NAFTA–TAA–04125 A; Allegheny Ludlum Corp., Jessop Plate Mill, Jessop O & T, Washington Flat Roll (Formerly Washington Steel Corp), Washington, PA and Houston, PA
NAFTA–TAA–04150; Holcroft, LLC, Livonia, MI
NAFTA–TAA–04198; PPG Industries, Inc., Springdale, PA
NAFTA–TAA–04184; Mountaineer Precision Tool and Mold, Inc., Waynesville, NC
NAFTA–TAA–04306; Parker Hannifin Corp., Process Filtration Div., Lebanon, IN
NAFTA–TAA–04191; Cox Target Media Sales, Inc., Washington, NC
NAFTA–TAA–04082; Fieldcrest Cannon, Inc., Pillowex, Plant 7, Salisbury, NC
NAFTA–TAA–04201; Contract Apparel, Inc., El Paso, TX
NAFTA–TAA–04344; A and B Component Parts, Shubuta, MS
NAFTA–TAA–04329; It's Personal Ltd, New York, New York
NAFTA–TAA–04188; M. Fine and Sons Manufacturing Co., Inc., Loretto, TN
NAFTA–TAA–04186; Excel Finishing, Inc., Old Fort, NC
NAFTA–TAA–04079; Royal Oak Enterprises, Inc., Licking, MO

The investigation revealed that the criteria for eligibility have not been met for the reasons specified.

NAFTA–TAA–04200; Crater Lake Potato Distributors, Klamath Falls, OR

The investigation revealed that workers of the subject firm did not produce an article within the meaning of Section 250(a) of the Trade Act, as amended.

Affirmative Determinations NAFTA–TAA

NAFTA–TAA–04316; Hatfield Trousers, Div. of Pincus Brothers, Hatfield, PA: November 17, 1999.
NAFTA–TAA–04231 & A; Talon, Inc., Lake City, SC and Stanley, NC: December 14, 2000.
NAFTA–TAA–04269; Snyder Walls Industries, Inc., Snyder, TX: October 25, 1999.
NAFTA–TAA–04114; Lotus Designs, Inc., Weaverville, NC: August 16, 1999.
NAFTA–TAA–04218; Designer Hearths, Inc., Missoula, MT: October 5, 1999.
NAFTA–TAA–04213; L and L Manufacturing Co., Inc., L and L Factory, Los Angeles, CA: September 19, 1999.
NAFTA–TAA–04326; Tyco Electronics, Sanford, ME: November 7, 1999.
NAFTA–TAA–04242; Hi-Line Storage Systems, Perkasie, PA: October 13, 1999.
NAFTA–TAA–4233; Wundies Santtony Wear, Seaming and Shipping Dept., Rockingham, NC: October 17, 1999.
NAFTA–TAA–04267; Alcoa Fujikura Ltd, Heavy Truck and Industrial Div., Shelbyville, KY: October 6, 1999.
NAFTA–TAA–04324; Johns Manville International, Inc., Corona, CA November 15, 1999.
NAFTA–TAA–04229; Maxxim Medical, Los Gatos, CA: September 15, 1999.
NAFTA–TAA–04299; Smith and Nephew, Inc., Ortho-Glass Dept., Charlotte, NC: November 13, 1999.
NAFTA–TAA–04220; Stimson Lumber Co., Booner, MT: October 4, 1999.
NAFTA–TAA–04328; Velvac, Inc., Inc., New Berlin, WI: November 24, 1999.
NAFTA–TAA–04193; MHPG, Inc., Whitinsville, MA: September 27, 1999.
NAFTA–TAA–04137; Quality Veneer and Lumber, Hood River, OR: august 14, 1999.
NAFTA–TAA–04335; Mediacopy, San Leandro, CA: November 21, 1999.
NAFTA–TAA–04037; Norton Packaging, Inc., Steel Pail Div., Oakland CA: July 20, 1999.
NAFTA–TAA–04263; Carolina Mills, Plant 25, St. Pauls, NC: October 21, 1999.
NAFTA–TAA–04341; Walls Industries, Inc., Boaz, AL: October 26, 1999.

NAFTA–TAA–04294; Rich and Me, Inc., Vernon, CA: November 3, 1999.
NAFTA–TAA–04272; Pyramid Mountain Lumber, Inc., Seeley Lake, MT: October 30, 1999.
NAFTA–TAA–04298; Cottrell, Ltd, LLC, Englewood, CO: November 14, 1999.
NAFTA–TAA–04178; Montgomery Hosiery Mill, Inc., Star, NC: August 25, 1999.
NAFTA–TAA–04318; Don Shapiro Industries, Inc., Action West Div., El Paso, TX: May 13, 2000.
NAFTA–TAA–04333; Karmazin Products Corp., Wyandotte, MI: November 28, 1999.
NAFTA–TAA–04343; Johnson Controls, Inc., Controls Group—Poteau Facility; Poteau, OK: November 29, 1999.
NAFTA–TAA–04175; Jomac-Wells Lamont Industry, Brunswick, MO: September 20, 1999.
NAFTA–TAA–04258; U.S. Label Artistic, Clinton, NC: October 25, 2000.
NAFTA–TAA–04366; Bynum Concepts, Inc., Lubbock, TX: November 30, 1999.
NAFTA–TAA–04332; Litton Network Access Systems, Roanoke, VA: November 28, 1999.

I hereby certify that the aforementioned determinations were issued during the month of December, 2000 January, 2001. Copies of these determinations are available for inspection in Room C–5311, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210 during normal business hours or will be mailed to persons who write to the above address.

Dated: January 5, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–936 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,134]

Antonio Clothing, New York, NY; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on September 25 in response to a worker petition which was filed by the Union of Needletrades, Industrial and Textile Employees on behalf of workers at Antonio Clothing, New York, New York.

The Department has been unable to locate an official of the company to obtain the information necessary to conduct an investigation. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C. this 5th day of December, 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–942 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,206]

Brown Wooten Mills, Inc., Ballston Plant, Mount Airy, NC; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on October 16, 2000, in response to a worker petition which was filed on October 16, 2000, on behalf of workers at Brown Wooten Mills, Inc., Ballston Plant, Mount Airy, North Carolina.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, DC this 28th day of December 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–940 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,341]

Caffall Brothers Forest Products, Inc., Wilsonville, OR; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on November 20, 2000 in response to a petition which was filed by the company on behalf of workers at Caffal Bros. Forest Products, Inc., Wilsonville, Oregon.

The company has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, DC this 29th day of December, 2000.

Linda Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–941 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,113]

Eramet Marietta Incorporated North Plant, Marietta, OH; Notice of Revised Determination on Reopening

On December 22, 2000, the Department, on its own motion, reopend its investigation for workers and former workers at the subject firm in Marietta, Ohio.

The initial petition filed with the Department on behalf of workers of Eramet Marietta Incorporated, North Plant, Marietta, Ohio, was denied on November 21, 2000. The investigation revealed that the ''contributed importantly'' criterion of the worker group eligibility requirements of section 222 of the Trade Act of 1974, as amended, was not met. Although the company reported that it would rely on impor purchases of manganese metal, company imports had not as yet occurred. The notice was published in the **Federal Register** on December 21, 2000. (65 FR 80457).

By letter dated, December 15, 2000, the company informed the Department that the subject firm has accepted the first delivery of imported managense metal.

Conclusion

After careful consideration of the new facts obtained on reopening, it is concluded that increased imports of articles like or directly competitive with manganese metal contributed importantly to the decline in sales and to the total or partial separation of workers at the subject firm. In accordance with the provisions of the Trade Act of 1974, I make the following revised determation:

All workers of Eramet Marietta Incorporated, North Plant, Marietta, Ohio, who became totally or partially separated from employment on or after September 11, 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 26th day of December 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–947 Filed 1–10–01; 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 January 22, 2001.

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 January 22, 2001.

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 18th day of December, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions Instituted on 12/18/2000]

TA–W	Subject firm (Petitioners)	Location	Date of petition	Product(s)
38,424	Georgia Pacific (PACE)	Baileyville, ME	12/01/2000	Lumber.
38,425	Ameripol Synpol Corp. (PACE)	Port Neches, TX	11/30/2000	Synthetic Rubber.
38,426	Universal Furniture (Co.)	Marion, NC	11/30/2000	Bedroom and Dining Room Furniture.
38,427	M.H. Rhodes (IAMAW)	Avon, CT	12/01/2000	Meters and Timing Devices.
38,428	U.S. Tape & Sticky Prod. (Wkrs)	Gloucester, MA	11/30/2000	Transparent Tape.
38,429	Paper Calmenson & Co. (IUE)	St. Paul, MN	12/04/2000	Ground Engaging Tools.
38,430	Lipton (Co.)	Dallas, TX	12/05/2000	Bulk Margarine.
38,431	Warm Springs Forest (Co.)	Warm Springs, OR	12/05/2000	Dimensional Lumber.
38,432	Singer Sewing Co. (Wkrs)	Murfreesboros, TN	11/28/2000	Industrial Sewing Machines.
38,433	Full Line Distributors (Co.)	Canton, GA	12/06/2000	T-Shirts, Sweatshirts, Rompers.
38,434	Condor DC Power Supplies (Co.)	Brentwood, NY	11/30/2000	Switching Power Supplies.
38,435	Blackfeet Writing (Wkrs)	Browning, MT	11/21/2000	Writing Instruments.
38,436	United States Leather (Wkrs)	El Paso, TX	12/01/2000	Leather Hides.
38,437	AWC Crestline (Co.)	Commerce, TX	11/30/2000	Wood Bi-Fold Doors.
38,438	Bend N Stretch (Wkrs)	Haileah, FL	11/30/2000	Fabrics.
38,439	Eastern Fine Paper (Co.)	Brewer, ME	12/05/2000	Opaques and Silicon Coated Release Paper.
38,440	U.S. Forest Industries (Co.)	Medford, OR	11/21/2000	Veneer, Plywood and Lumber.
38,441	New Process Gear (UAW)	East Syracuse, NY	11/29/2000	Transfer Cases, Manual Transmissions.
38,442	CMI Industries (Co.)	Clinton, SC	12/04/2000	Unfinished Cloth.
38,443	NTN/BCA Corp. (Wkrs)	Lititz, PA	12/03/2000	Bearings—Auto and Farm Equipment.
38,444	Berenfield Containers (Wkrs)	Mason, OH	12/04/2000	Steel Drums.
38,445	Burlington Resources (Wkrs)	Farmington, NM	12/01/2000	Oil and Gas Exploration.
38,446	Sherwood Dash USA (Wkrs)	Rancho Cucamong, CA.	10/13/2000	Auto Wood Dash Kits.
38,447	Pinebluff (Wkrs)	Pinebluff, NC	12/04/2000	Curtains.
38,448	Fruit of the Loom (Wkrs)	Osceola, RA	11/27/2000	Textiles.
38,449	Hasbro (Wkrs)	El Paso, TX	12/04/2000	Toys.
38,450	Specialty Minerals (Wkrs)	Mobile, AL	12/06/2000	Calcium Carbonates.
38,451	Chicago Lock (Wkrs)	Pleasant Prairi, WI	12/05/2000	Security Locks for Vending Machines.
38,452	ARA Cutting (Wkrs)	Miami, FL	12/06/2000	Levi Dockers and Shorts.
38,453	Thomas and Betts (Co.)	Pembroke, MA	12/06/2000	Electronic Photocontrols.
38,454	Centec Roll (Wkrs)	Bethlehem, PA	12/07/2000	Rolls for Rolling Mill Operations.
38,455	Plainwell Paper (PACE)	Plainwell, MI	12/07/2000	Printing Papers.
38,456	Butterfield Logging (Co.)	Post Falls, ID	11/30/2000	Logs.
38,457	Copper Range Company (Co.)	White Pine, MI	11/09/2000	Cathode Copper.

[FR Doc. 01–937 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,418]

Harbor Industries Traverse City, MI; Notice of Termination of Investigation

Pursuant to section 221 of the Trade Act of 1974, an investigation was initiated on December 11, 2000, in response to a worker petition which was filed on behalf of workers at Harbor Industries, Traverse City, Michigan.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed at Washington, D.C. this 20th day of December 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–939 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–4280]

Caffall Brothers Forest Products, Inc., Wilsonville, OR; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182) concerning transitional adjustment assistance, hereinafter called NAFTA–TAA and in accordance with section 250(a), Subchapter 2, Title II, of the Trade Act of 1974, as amended (19 USC 2331), an investigation was initiated on November 9, 2000 in response to a petition filed by company officials on behalf of workers at Caffall Bros. Forest Products, Inc., Wilsonville, Oregon.

The company has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, DC this 29th day of December, 2000.

Linda Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–945 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA—4238]

Dekko Automotive Technologies Mount Ayr, IA; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–1 concerning transitional adjustment assistance, hereinafter called NAFTA–TAA and in accordance with section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974, as amended (19 USC 2331), an investigation was initiated on October 13, 2000, in response to a petition filed on behalf of workers at Dekko Automotive Technologies, Mount Ayr, Iowa. Workers produce wire harness assembles.

The petitioner has stated that they no longer wish to pursue the petition for the Mount Ayr facility. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C. this 20th day of December, 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–938 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–004227]

Harriet & Henderson Yarns, Incorporated, Berryton Plant, Summerville, GA; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–1 concerning transitional adjustment assistance, hereinafter called NAFTA–TAA and in accordance with section 250(a), Subchapter D, Chapter 2, Title II, of the Trade Act of 1974, as amended (19 USC 2331), an investigation was initiated on October 16, 2000 in response to a petition filed on behalf of workers at Harriet & Henderson Yarns, Inc., Berryton Plant, Summerville, Georgia. Workers produced cotton yarn.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, DC this 28th day of December 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–946 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–38,192 and NAFTA–4187]

Metal Powder Products Company Logan, OH; Notice of Negative Determination Regarding Application for Reconsideration

By application dated December 13, 2000, the International Association of Machinists and Aerospace Workers, Local Lodge 55, District 28, requested administrative reconsideration of the Department's negative determination regarding eligibility to apply for Trade Adjustment Assistance (TAA) and North American Free Trade Agreement-Transitional Adjustment Assistance (NAFTA–TAA), applicable to workers and former workers of the subject firm. The denial notices were signed November 30, 2000, and published in the **Federal Register** on December 21, 2000; the TAA at (65 FR 80457) and the NAFTA–TAA at (65 FR 80458).

Pursuant to 29 CFR 90.18(c) reconsideration may be granted under the following circumstances:

(1) If it appears on the basis of facts not previously considered that the determination complained of was erroneous;

(2) If it appears that the determination complained of was based on a mistake in the determination of facts not previously considered; or

(3) If in the opinion of the Certifying Officer, a misinterpretation of facts or of the law justified reconsideration of the decision.

The denial of TAA for workers producing powdered metal parts for industrial applications at Metal Powder Products Company, Logan, Ohio, was based on the finding that the ''contributed importantly'' criterion of the group eligibility requirements of section 222 of the Trade Act of 1974 was not met. The subject firm transferred all of the production from Logan, Ohio to other domestic facilities. Prior to the closure of the Metal Powder Products Company plant in Logan, Ohio, sales and production remained nearly constant.

The Department's denial of NAFTA–TAA for the same worker group was based on the finding that criteria (3) and (4) of the group eligibility requirements of paragraph (a)(1) of section 250 of the Trade Act of 1974, as amended, were not met. There was no shift in production of powder metal parts from the subject firm to Mexico or Canada, nor were there company imports of like or directly competitive products from Mexico or Canada.

The petitioner asserts that the subject firm took some of the key management staff to the Powder Metal Products plant in Mexico and production there has increased. Although not elaborated on in the initial investigation, the company acknowledged a recent acquisition of a plant in Mexico. That plant, however, serves the auto market in that country and none of the production was shifted from Logan, Ohio to Mexico, nor will any of the production be coming back to the United States.

The petitioner also provided a shipping label from Metal Powder Specialities in Logan, Ohio, to an address in Mexico. The shipping label to Mexico, by itself, does not present any new information which would warrant worker group certification.

Conclusion

After review of the application and investigative findings, I conclude that there has been no error or misinterpretation of the law or of the facts which would justify reconsideration of the Department of Labor's prior decisions. Accordingly, the application is denied.

Signed at Washington, DC this 26th day of December 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 01–948 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[NAFTA–4288]

Posies Inc., Rockport, ME; Notice of Termination of Investigation

Pursuant to Title V of the North American Free Trade Agreement Implementation Act (Pub. L. 103–183) concerning transitional adjustment assistance, hereinafter called NAFTA–TAA and in accordance with section 250(a), Subchapter D, Chapter 2, title II, of the Trade Act of 1974, as amended (19 U.S.C. 2331), an investigation was initiated on November 13, 2000, in response to a petition filed on behalf of workers at Posies Inc., Rockport Maine.

The petitioner has requested that the petition be withdrawn. Consequently, further investigation in this case would serve no purpose, and the investigation has been terminated.

Signed in Washington, D.C. this 28th day of December, 2000.

Linda G. Poole,

Certifying Officer Division of Trade Adjustment Assistance.

[FR Doc. 01–944 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[Docket No. NAFTA–03838 and NAFTA–03838A]

Rugged Sportswear, Siler City, North Carolina; Rugged Sportswear, Walstonburg, North Carolina; Amended Certification Regarding Eligibility to Apply for NAFTA Transitional Adjustment Assistance

In accordance with section 250(a), Subchapter 2, Title II, of the Trade Act of 1974, as amended (19 U.S.C. 2273), the Department of Labor issued a Certification of Eligibility to Apply for NAFTA Transitional Adjustment Assistance on May 30, 2000, applicable to workers of Rugged Sportswear, Siler City, North Carolina. The notice was published in the **Federal Register** on June 8, 2000 (65 FR 36470).

At the request of the company, the Department reviewed the certification for workers of the subject firm. New information shows that worker separations occurred at the subject firms' Walstonburg, North Carolina facility when it closed in October, 2000. The workers were engaged in the production of sweat shirts, sweat pants and sweat shorts.

Accordingly, the Department is amending the certification to include the workers at the Walstonburg, North Carolina location of Rugged Sportswear.

The intent of the Department's certification is to include all workers of Rugged Sportswear who were adversely affected by a shift of production to Mexico.

The amended notice applicable to NAFTA–03838 is hereby issued as follows:

''All workers of Rugged Sportswear, Siler City, North Carolina (NAFTA–03838) and Walstonburg, North Carolina (NAFTA–03838A) who became totally or partially separated from employment on or after March 31, 1999 through May 30, 2002 are eligible to apply for NAFTA–TAA under Section 250 of the Trade Act of 1974.''

Signed at Washington, D.C. this 15th day of December, 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 01–943 Filed 1–10–01; 8:45 am]

BILLING CODE 4510–30–M

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice 01–002]

5th Digital Earth Community Meeting

AGENCY: National Aeronautics and Space Administration (Lead Agency).

ACTION: Notice of meeting.

SUMMARY: The Federal Interagency Digital Earth Working Group will hold the 5th Digital Earth Community Meeting that will focus on accomplishments thus far, and the future of Digital Earth. The intent of this meeting is to continue the efforts of enabling and facilitating the evolution of Digital Earth, a digital representation of the planet that will allow people to access and apply geo-spatial data from multiple resources. Federal, state, and local government along with private industry, academia and others will participate in presentations, workshops and panel discussions. Together we will educate and empower each other to continue to develop the Digital Earth environment.

DATES: Wednesday, January 31, 2001 from 8 am to 5 pm. Registration beginning at 7:30 am.

ADDRESSES: Capitol Union Building, Penn State University at Harrisburg, 777 W. Harrisburg Pike, Middletown, PA 17057.

FOR FURTHER INFORMATION CONTACT: To register for the meeting, please contact PSU Continuing Education at 717–948–6505 or e-mail: pshceweb@psu.edu. If you would like to present at this meeting, please contact Dr. Todd Bacastow at 814–863–0049 or e-mail bacastow@psu.edu. The deadline for registration is Wednesday, January 24, 2001. This is an outreach service of the College of Earth and Mineral Sciences.

SUPPLEMENTARY INFORMATION:

Format: The one day session will concentrate on presentations, workshops, and panel discussions. The status of The National Digital Earth Initiative, What is Digital Earth and It's Community, Using Digital Earth Guidelines, Developing Applications,

Involving Students, and Data Accessibility will all be discussed. Upcoming conferences, organizational committees and collaborative efforts will be addressed as well. There will be space available for personal demonstrations—and discussions throughout the day. Although the meeting is open to all interested parties, time availability for presentations and demonstrations is limited and will be allocated on a first come basis. All interested parties must contact Dr. Todd Bacastow by January 17, 2001.

Web Information: Additional details on the Community Meeting will be posted to *www.digitalearth.gov* in the near future.

Dated: January 2, 2001.

Thomas S. Taylor,

NASA Digital Earth Program Manager.

[FR Doc. 01–785 Filed 1–9–01; 8:45 am]

BILLING CODE 7510–01–P

NATIONAL SCIENCE FOUNDATION

Comment Request: National Science Foundation Proposal/Award Information—Grant Proposal Guide

AGENCY: National Science Foundation.

ACTION: Notice.

SUMMARY: The National Science Foundation (NSF) is announcing plans to request renewed clearance of this collection. In accordance with the requirement of Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we are providing opportunity for public comment on this action. After obtaining and considering public comment, NSF will prepare the submission requesting OMB clearance of this collection for no longer than 3 years.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information shall have practical utility; (b) the accuracy of the Agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information on respondents, including through the use of automated collection techniques or other forms of information technology; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

DATES: Written comments should be received by March 12, 2001 to be assured of consideration. Comments received after that date will be considered to the extent practicable.

ADDRESSES: Written comments regarding the information collection and requests for copies of the proposed information collection request should be addressed to Suzanne Plimpton, Reports Clearance Officer, National Science Foundation, 4201 Wilson Blvd., Rm. 295, Arlington, VA 22230, or by e-mail to splimpto@nsf.gov.

FOR FURTHER INFORMATION CONTACT: Suzanne Plimpton on (703) 292–7556 or send e-mail to splimpto@nsf.gov. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

SUPPLEMENTARY INFORMATION:

Title of Collection: ''National Sciences Foundation Proposal/Award Information-Grant Proposal Guide''

OMB Approval Number: 3145–0058.

Expiration Date of Approval: July 31, 2003.

Type of Request: Intent to seek approval to extend with revision an information collection for three years.

Proposed Project: The National Science Foundation Act of 1950 (Public Law 81–507) set forth NSF's mission and purpose:

''To promote the progress of science; to advance the national health, prosperity, and welfare; to secure the national defense. * * *''

The Act authorized and directed NSF to initiate and support:

- Basic scientific research and research fundamental to the engineering process;
- Programs to strengthen scientific and engineering research potential;
- Science and engineering education programs at all levels and in all the various fields of science and engineering;
- Programs that provide a source of information for policy formulation; and
- Other activities to promote these ends. Over the years, NSF's statutory authority has been modified in a number of significant ways. In 1968, authority to support applied research was added to the Organic Act. In 1980, The Science and Engineering Equal Opportunities Act gave NSF standing authority to support activities to improve the participation of women and minorities in science and engineering.

Another major change occurred in 1986, when engineering was accorded equal status with science in the Organic Act. NSF has always dedicated itself to providing the leadership and vision needed to keep the words and ideas embedded in its mission statement fresh and up-to-date. Even in today's rapidly changing environment, NSF's core purpose resonates clearly in everything it does: promoting achievement and progress in science and engineering and enhancing the potential for research and education to contribute to the Nation. While NSF's vision of the future and the mechanisms it uses to carry out its charges have evolved significantly over the last four decades, its ultimate mission remains the same.

Use of the Information: The regular submission of proposals to the Foundation is part of the collection of information and is used to help NSF fulfill this responsibility by initiating and supporting merit-selected research and education projects in all the scientific and engineering disciplines. NSF receives more than 30,000 proposals annually for new projects, and makes approximately 10,000 new awards. Support is made primarily through grants, contracts, and other agreements awarded to approximately 2,800 colleges, universities, academic consortia, nonprofit institutions, and small businesses. The awards are based mainly on evaluations of proposal merit submitted to the Foundation (proposal review is cleared under OMB Control No. 3145–0060).

The Foundation has a continuing commitment to monitor the operations of its information collection to identify and address excessive reporting burdens as well as to identify any real or apparent inequities based on gender, race, ethnicity, or disability of the proposed principal investigator(s)/project director(s) or the co-principal investigator(s)/co-project director(s).

Burden on the Public: The Foundation estimates that an average of 120 hours is expended for each proposal submitted. An estimated 38,000 proposals are expected during the course of one year. These 4,560,000 public burden hours annually.

Dated: January 8, 2001.

Suzanne H. Plimpton,

NSF Reports Clearance Officer.

[FR Doc. 01–841 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Advanced Computational Infrastructure & Research; Notice of Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meetings of the Special Emphasis Panel in Advanced Computational Infrastructure & Research (#1185):

Date/Time and Place

January 29–30, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA
February 5–6, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA
February 8–9, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA
February 12–13, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

Type of Meetings: Closed.

Contact Person: Dr. Charles H. Koelbel, National Science Foundation, 4201 Wilson Boulevard, Room 1122, Arlington, VA 22230, (703) 292–8970.

Purpose of Meetings: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Information Technology Research pre-proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b (c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–880 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Advanced Networking and Infrastructure Research; Notice of Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meetings of the Special Emphasis Panel in Advanced Networking and Infrastructure Research (#1207):

Date/Time and Place

January 29–30, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA
February 1–2, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA
February 8–9, 2001; 8 a.m.–5 p.m.—Westin LAX Angeles, CA

Type of Meetings: Closed.

Contact Person: Taieb Znati, National Science Foundation, 4201 Wilson Boulevard, Room 1175, Arlington, VA 22230, (703) 292–8949.

Purpose of Meetings: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Information Technology Research pre-proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–881 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Civil and Mechanical Systems; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Civil and Mechanical Systems (1205).

Date and Time: February 22–23, 2001; 8 a.m. to 5 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 580, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Thomas Anderson or George E. Brown, Jr., National Science Foundation, 4201 Wilson Boulevard, Room 545, Arlington, VA 22230. Telephone: (703) 292–8360.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To discuss progress and plans of proposals.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information, financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–885 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Civil and Mechanical Systems; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Civil and Mechanical Systems (1205).

Date and Time: February 6, 2001, 8:30 a.m. to 5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Room 530, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. Jorn Larsen-Basse, National Science Foundation, 4201 Wilson Boulevard, Room 545, Arlington, VA 22230. Telephone: (703) 292–8360.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate nominations for the FY'01 Surface Engineering and Material Design Review Panel as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–888 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Computing-Communications Research; Notice of Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meetings of the Special Emphasis Panel in Computing-Communications Research (#1192):

Date/Time and Place

January 29, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA
February 1–2, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA
February 5–6, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA
February 12–13, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

Type of Meetings: Closed.

Contact Person: Frank Anger, National Science Foundation, 4201 Wilson Boulevard, Room 1145, Arlington, VA 22230, (703) 292–8911.

Purpose of Meetings: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Information Technology Research pre-proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a

proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–883 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Electrical and Communications Systems; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Electrical and Communications System (1196).

Date and Time: January 18–19, 2001; 8:30 a.m. to 5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Room 830, Arlington, VA 22230.

Type of Meeting: Closed.

Contact Person: Dr. Kishan Baheti, National Science Foundation, 4201 Wilson Boulevard, Room 675, Arlington, VA 22230. Telephone: (703) 292–8339.

Purpose: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate research proposals in the Electronics, Photonics and Device Technologies Program as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–879 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Experimental and Integrative Activities; Notice of Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meetings of the Special Emphasis Panel in Experimental and Integrative Activities (#1193):

Date/Time and Place

January 29–30, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

February 1–2, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA

February 5–6, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

February 12–13, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

Type of Meetings: Closed.

Contact Person: Gary Strong, National Science Foundation, 4201 Wilson Boulevard, Room 1160, Arlington, VA 22230, (703) 292–8980.

Purpose of Meetings: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Information Technology Research pre-proposals as part of selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–882 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Human Resource Development; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended) the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Human Resource Development (1199).

Date and Time: February 1–2, 2001; 8:30 am–5:30 pm.

Place: National Science Foundation, 4201 Wilson Boulevard, Rooms 830, Arlington, VA 22230.

Type of Meeting: Part-Open.

Contact Person: Drs. A. James Hicks, Victor Santiago, Roosevelt Johnson and Joseph Bragin, Division of Human Resource Development, Room 815, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230. Telephone: (703) 306–1632.

Purpose of Meeting: To carryout a Committee of Visitors review of Historically Black Colleges and Universities—UP (HBCU), Louis Stokes Alliances for Minority Participation (LSAMP), Alliance for Graduate Education and the Professoriate (AGEP) and Centers for Research Excellence in Science & engineering (CREST).

Agenda:

Closed: February 1, 2001, 8:30 am–5:30 pm and February 2, 2001, 8:30 am–3:30 pm. To review the merit review process covering funding decisions made during the immediately preceding three fiscal years.

Open: February 2, 2001, 3:30 pm–5:30 pm. Discussions on the impact of projects funded and an evaluation of the programs.

Reason for Closing: During the closed session, the Committee will be reviewing proposal actions that will include privileged intellectual property and personal information that could harm individuals if they were disclosed. Such deliberations are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–887 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Information and Intelligent Systems; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation (NSF) announces the following meeting:

Name: Special Emphasis Panel in Information and Intelligent Systems (1200).

Date and Time: January 16–17, 2001; 8:30 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 1120, Arlington, VA.

Type of Meeting: Closed.

Contact Persons: Ephraim Glinert, Deputy Division Director, Division of Information and Intelligent Systems, Room 1115, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230, Telephone: (703) 292–8930.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Robotics and Human Augmentation proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–877 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Information and Intelligent Systems; Notice of Meetings

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meetings of the Special Emphasis Panel in Information and Intelligent Systems (#1200):

Date/Time and Place

January 29–30, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

February 5–6, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

February 8–9, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA

February 12–13, 2001; 8 a.m.–5 p.m.—National Science Foundation, 4201 Wilson Boulevard, Arlington, VA

February 22–23, 2001; 8 a.m.–5 p.m.—Westin LAX Los Angeles, CA

Type of Meetings: Closed.

Contact Person: Michael Lesk, National Science Foundation, 4201 Wilson Boulevard, Room 1115, Arlington, VA 22230, (703) 292–8930.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Information Technology Research pre-proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2000.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–884 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Materials Research; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463 as amended), the National Science Foundation announces the following meetings:

Name: Special Emphasis panel in Materials Research (1203).

Dates and Times: January 25–26, 2001; 8 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 390, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. Bruce Taggart, Program Director, Materials Theory Program, Division of Materials Research, Room 1065, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230, Telephone (703) 292–4941.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: Review and evaluate proposals as part of the selection process to determine finalists considered for support for the FY 2001 Nanoscale Exploratory Research (NER) proposals submitted in response to the Nanoscale Science and Engineering Initiative.

Reason for Closing: The proposals being evaluated include information of a proprietary or confidential nature, including technical information; financial data, such as salaries and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552 b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–872 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Mathematical Sciences; Notice of Meeting

In accordance with the federal Advisory Committee (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Mathematical Sciences (1204).

Date and Time: January 29–31, 2001; 8:30 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. Dmitry Khavinson, 4201 Wilson Boulevard, Room 1025, Arlington, VA 22230. Telephone: (703) 292–4871.

Purpose of Meeting: To provide advice and recommendations concerning proposal submitted to NSF for financial support.

Agenda: To review and evaluate proposals concerning the Foundations Panel Meeting, as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–878 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Physics; Notice Of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Physics (1208).

Date and Time: January 29–30, 2001; 8:30 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 370, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. C. Denise Caldwell, 4201 Wilson Boulevard, Room 1015, Arlington, VA 22230. Telephone: (703) 292–7371.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to the NSF for financial support.

Agenda: To review and evaluate Nanoscale Science and Engineering proposals as part of the evaluation process for funding.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; information on personnel and proprietary date for present and future subcontracts. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–873 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Physics; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Physics (1208).

Date and Time: February 1–2, 2001; 8 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 370, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. C. Denise Caldwell, 4201 Wilson Boulevard, Room 1015, Arlington, VA 22230. Telephone: (703) 292–7371.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to the NSF for financial support.

Agenda: To review and evaluate Nanoscale Science and Engineering proposals as part of the evaluation process for funding.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; information on personnel and proprietary data for present and future subcontracts. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–874 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Physics; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting:

Name: Special Emphasis Panel in Physics (1208).

Date/Time: February 8–9, 2001; 8 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. Richard Isaacson, National Science Foundation, 4201 Wilson Boulevard, Room 315, Arlington, VA 22230. Telephone: (703) 292–7375.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: Review and evaluate proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; information on personnel and proprietary data for present and future subcontracts. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–875 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Physics; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting.

Name: Special Emphasis Panel in Physics (1208).

Date/Time: January 25–26, 2001; 8 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Arlington, VA.

Type of Meeting: Closed.

Contact Person: Dr. Richard Isaacson, National Science Foundation, 4201 Wilson Boulevard, Room 315, Arlington, VA 22230. Telephone: (703) 292–7375.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: Review and evaluate proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information, information on personnel and proprietary data for present and future subcontracts. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–876 Filed 1–11–01; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Advisory Panel for Physiology and Ethology; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation (NSF) announces the following meeting.

Name: Advisory Panel for Physiology and Ethology (1160).

Date and Time: February 7–9, 2001, 8 a.m.–5 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Arlington, VA.

Type of Meeting: Part-Open.

Contact Persons: Dr. Kimberlyn Williams, and Dr. Stephen Vessey, National Science Foundation, 4201 Wilson Boulevard, Room 685, Arlington, VA 22230. Telephone: (703) 292–8421.

Purpose of Meeting: To provide advice and recommendations proposals submitted to the NSF for financial support.

Minutes: May be obtained from the contact person(s) listed above.

Agenda: Open Session: February 8, 2001, 4 p.m. to 5 p.m.—discussion or research trends, opportunities and assessment procedures in Integrative Biology and Neuroscience.

Closed Session: February 7, 2001, 8 a.m. to 5 p.m.; February 8, 2001, 8 a.m. to 4 p.m.; February 9, 2001, 8 a.m. to 5 p.m. To review and evaluate the Doctoral Dissertation Improvement Grants as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: January 8, 2001.

Karen J. York,

Committee Management Officer.

[FR Doc. 01–886 Filed 1–10–01; 8:45 am]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

Notice of a Public Meeting on Assessing Future Regulatory Research Needs

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of public meeting.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) will hold a third meeting of nuclear experts from the government, the nuclear industry, academia, and the public on January 24–25, 2001. As a result of the first two meetings, the nuclear experts issued a draft report composed of the individual views of the experts on the role and direction of regulatory research. The draft report contains a number of recommendations. The purpose of this meeting is to evoke and evaluate strategies for implementing the recommendations. RES will provide the panel with RES perspectives. The licensing offices and the Regions will also provide an overview of their technical assistance and research activities. The meeting is open to the public and all interested parties may attend.

DATES: The meeting will be held from 8:00 AM to 5:00 PM on January 24 and 25, 2001, at the Marriott Residence Inn located at 7335 Wisconsin Avenue in Bethesda, Maryland 20804. The telephone number of the hotel is 301–718–0200.

FOR FURTHER INFORMATION CONTACT: Questions with respect to this meeting should be referred to James W. Johnson, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission at (301) 415–6293; fax 301–415–5153; E-mail *jwj@nrc.gov.*

SUPPLEMENTARY INFORMATION: Parking is available in the hotel for a modest cost. Additional parking in Bethesda is somewhat limited. The hotel can also be reached by Metro.

The hotel is located one block south of the Bethesda Metro stop on the Red Line and is on the opposite side of the street from the Metro station. Seating for the public is limited and therefore will be on a first-come, first serve basis.

Dated at Rockville, Maryland, this 5th day of January 2001.

For the Nuclear Regulatory Commission.

Ashok C. Thadani,

Director, Office of Nuclear Regulatory Research, U.S. Nuclear Regulatory Commission.

[FR Doc. 01–834 Filed 1–10–01; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

Consolidated Guidance About Materials Licenses: Program-Specific Guidance About Special Nuclear Material of Less Than Critical Mass Licenses

AGENCY: Nuclear Regulatory Commission (NRC).

ACTION: Notice of availability.

SUMMARY: The NRC is announcing the availability of final NUREG–1556, Volume 17, ''Consolidated Guidance about Materials Licenses: Program-Specific Guidance about Special Nuclear Material of Less Than Critical Mass Licenses,'' dated November 2000.

The NRC is using Business Process Redesign techniques to redesign its materials licensing process, as described in NUREG–1539, ''Methodology and Findings of the NRC's Materials Licensing process Redesign.'' A critical element of the new process is consolidating and updating numerous guidance documents into a NUREG-series of reports. This final NUREG report is the 17th guidance document developed to support an improved materials licensing process.

This guidance is intended for use by applicants, licensees, and the NRC staff, and will also be available to Agreement States. This document combines and updates the guidance found in Regulatory Guide 10.3 ''Guide for the preparation of Applications for Special Nuclear Material Licenses of Less Than Critical mass Quantities.'' This final report takes a more risk-informed, performance-based approach to licensing quantities of special nuclear material of less than critical mass, and reduces the information (amount and level of detail) needed to support an application to use this material.

A free single copy of final NUREG 1556, Volume 17, may be requested by writing to the US Nuclear Regulatory Commission, ATTN: Mrs. Carrie Brown, Mail Stop TWFN 9–C24, Washington, DC 20555–0001. Alternatively, submit requests through the Internet by addressing electronic mail to *cxb@nrc.gov.* A copy of this final NUREG 1556 Volume 17, is available for inspection and/or copying for a fee in the NRC Public Document Room, 2120 L Street, NW. (Lower Level), Washington, DC 20555–0001.

FOR FURTHER INFORMATION CONTACT: Mrs. Carrie Brown, TWFN 9–F–24, Division of Industrial and Medical Nuclear Safety, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555, telephone (301) 415–8092.

Electronic Access: Final NUREG–1556, Vol. 17 is available electronically by visiting the NRC's Home Page (*http://www.nrc.gov/nrc/nucmat.html*)

Dated at Rockville, Maryland, this 21st day of December, 2000.

For the Nuclear Regulatory Commission.

Patricia K. Holahan,

Chief, Rulemaking and Guidance Branch, Division of Industrial and Medical Nuclear Safety, NMSS.

[FR Doc. 01–833 Filed 1–10–01; 8:45 am]

BILLING CODE 7590–01–M

SECURITIES AND EXCHANGE COMMISSION

[Rule 15g–9; SEC File No. 270–325; OMB Control No. 3235–0385]

Proposed Collection; Comment Request

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'') is soliciting comment on the collection of information described below. The Commission plans to submit this existing collection of information to the Office of Management and Budget for extension and approval.

Rule 15g–9, Sales Practice Requirements for Certain Low-Priced Securities

Section 15(c)(2) of the Securities Exchange Act of 1934 (the ''Exchange Act'') authorizes the Commission to promulgate rules that prescribe means reasonably designed to prevent fraudulent, deceptive, or manipulative practices in connection with over-the-counter (''OTC'') securities transactions. Pursuant to this authority, the Commission in 1989 adopted rule 15a–6 (the ''Rule''), which was subsequently redesignated as rule 15g–9, 17 CFR 240.15g–9. The Rule requires broker-dealers to produce a written suitability determination for, and to obtain a written customer agreement to, certain recommended transactions in low-priced stocks that are not registered on a national securities exchange or authorized for trading on NASDAQ, and whose issuers do not meet certain minimum financial standards. The Rule is intended to prevent the indiscriminate use by broker-dealers of fraudulent, high-pressure telephone sales campaigns to sell low-priced securities to unsophisticated customers.

The staff estimates that approximately 270 broker-dealers incur an average burden of 78 hours per year to comply with this rule. Thus, the total annual burden to comply with the Rule is estimated at 21,060 hours (270 × 78).

Written comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimates of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information on respondents; and (d) ways to minimuze the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Consideration will be given to comments and suggestions submitted in writing within 60 days of this publication.

Please direct your comments to Michael E. Bartell, Associate Executive Director, Office of Information Technology, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549.

Dated: January 4, 2001.

Jonathan G. Katz,

Secretary.

[FR Doc. 01–788 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

Issuer Delisting; Notice of Application to Withdraw From Listing and Registration; (Ceridian Corporation, Common Stock, $.50 Par Value) File No. 1–01969

January 4, 2001.

Ceridian Corporation (''Company'') has filed applications with the Securities and Exchange Commission (''Commission''), pursuant to section 12(d) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 12d2–2(d) thereunder,[2] to withdraw its Common Stock, $.50 par value (''Security''), from

[1] 15 U.S.C. 78*l*(d).

[2] 17 CFR 240.12d2–2(d).

listing and registration on the Pacific Exchange, Inc. (''PCS'') and on the Chicago Stock Exchange, Inc. (''CHX'').

In addition to its listing on the PCX and CHX, the Security is currently listed on the New York Stock Exchange, Inc. (''NYSE''). The Company has resolved to reduce the number of listings of its Security in order to avoid the costs associated with maintaining multiple listings. The Comany desires to continue only its listing on the NYSE.

The Company has stated in its application that it has complied with the respective rules of the PCX and CHX governing the withdrawal of security by its issuer and that both the PCX and the CHX have in turn indicated that they will not oppose such proposed withdrawals. The Company's application shall not have any effect on the Security's continued listing on the NYSE or on its registration under section 12(b) of the Act.[3]

Any interested person may, on or before January 26, 2001, submit by letter to the Secretary of the Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609, facts bearing upon whether the application has been made in accordance with the respective rules of the PCX and CHX and what terms, if any, should be imposed by the Commission for the protection of investors. The Commission, based on the information submitted to it, will issue an order granting the application after the date mentioned above, unless the Commission determines to order a hearing on the matter.

For the Commission by the Division of Market Regulations, pursuant to delegated authority.[4]

Jonathan G. Katz,

Secretary.

[FR Doc. 01–789 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43798; File No. SR–BSE–00–12]

Self-Regulatory Organizations; Order Approving Proposed Rule Change by the Boston Stock Exchange, Inc. Relating to the Time Period for Filing Claims Against Specialists

January 3, 2001.

I. Introduction

On September 21, 2000, the Boston Stock Exchange, Inc. (''BSE''), filed with the Securities and Exchange Commission (''Commission'') a proposed rule change pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder.[2] On October 3, 2000, the BSE filed Amendment No. 1 to the proposed rule change.[3] Notice of the proposed rule change, as amended, was published for comment in the **Federal Register** on November 1, 2000.[4] No comments were received on the proposal. This order approves the proposed rule change.

II. Description of the Proposed Rule Change

The BSE proposes to amend Chapter XV, Section 14, of its rules, titled ''Claims and Reports Against Specialists''. The amendment shortens the permitted time period for: filing claims against specialists relating to erroneous comparisons and the omission of a report that was properly made, to three business days. The amendment will bring the time frames in the rule into parity with the settlement period required by Rule 15c6–1 under the Act.[5]

III. Discussion

After careful review, 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.[6] In particular, the Commission believes that the proposal is consistent with section 6(b)(5) of the Act,[7] which requires, among other things, that the rules of an exchange be designed to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities. The Commission believes that shortening the time frame within which a claim relating to an erroneous comparison must be made so that it is consistent with the settlement time frame mandated by Rule 15c6–1 under the Act should promote timely settlement of securities transactions.

IV. Conclusion

For the foregoing reasons, the Commission finds that the proposed rule change is consistent with the requirements of the Act, and the rules and regulations thereunder.

It Is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[8] that the proposed rule change (File No. SR–BSE–00–12), as amended, is approved.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[9]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–790 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Docket No. Release No. 34–43810; File No. SR–EMCC–00–07]

Self-Regulatory Organizations; Emerging Markets Clearing Corporation; Notice of Filing and Order Granting Accelerated Approval of a Proposed Rule Change Related to Making a Security Ineligible for Processing

January 4, 2001.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on August 28, 2000, the Emerging Markets Clearing Corporation (''EMCC'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which items have been prepared primarily by EMCC. The Commission is publishing this notice and order to solicit comments from interested persons and to grant accelerated approval of the proposal.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change permits EMCC in certain circumstances to remove a security from its list of EMCC eligible instruments and to exit open

[3] 15 U.S.C. 78*l*(b).

[4] 17 CFR 200.30–3(a)(1).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] In Amendment No. 1, the Exchange made certain technical changes relating, *inter alia,* to the format of the filing, the date of effectiveness of the proposed rule change, and the authorization procedures of the Exchange. *See* Amendment No. 1, filed October 3, 2000.

[4] *See* Securities Exchange Act Release No. 43506 (November 1, 2000), 65 FR 67783 (November 13, 2000).

[5] 17 CFR 240.15c6–1.

[6] In approving this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78(c)(f).

[7] 15 U.S.C. 78f(b)(5).

[8] 15 U.S.C. 78s(b)(2).

[9] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

transactions in that security from its clearance system.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, EMCC 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. EMCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of such statements.[2]

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

EMCC's rules permit EMCC to remove a security from its list of those securities eligible for processing through EMCC's system in certain circumstances. However, EMCC's rules do not permit EMCC to exit any pending trades in such a security from its system for any reason other than where the security is no longer deliverable through a qualified securities depository. Without the ability to exit pending trades from its processing system, there may be circumstances where a member may lose important rights in a security by virtue of the continued inclusion of its trades in EMCC's processing system.

The proposed rule change therefore would permit EMCC to make a security ineligible for processing in its system and to exit pending trades in that security by issuing appropriate instructions to its affected members if in EMCC's judgment a member may lose important rights by reason of the security's continued status as an EMCC eligible instrument. For example, where an EMCC eligible instruments is subject to a restructuring which includes a voluntary exchange offer, a party to a pending trade in that security may lose the right to receive the exchange security of its original counterparty does not take appropriate protective action. In that case, the parties can best protect their rights by dealing directly with each other outside of EMCC. In that event, EMCC would notify all members of the security's removal and issue instructions in a manner it determines is appropriate to the affected members and to the extent applicable to the relevant qualified securities depository naming members as the contraparties to the affected transactions. EMCC would issue such instructions with a view towards minimizing the number of such instructions issued in a given instance.

EMCC believes that this rule change will facilitate the prompt and accurate clearance and settlement of emerging market securities transactions and therefore believes that it is consistent with section 17A(b)(3)(F) of the Act.[3]

(B) Self-Regulatory Organization's Statement on Burden on Competition

EMCC does not believe that the proposed rule change will have an impact on or impose a 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 relating to the proposed rule change have been solicited or received. EMCC will notify the Commission of any written comments received by EMCC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder and particularly with the requirements of section 17A(b)(3)(F).[4] Section 17A(b)(3)(F) requires that the rules of a clearing agency be designed to promote the prompt and accurate clearance and settlement of securities transactions. The proposed rule is designed and should enable EMCC to help its members not lose important rights with respect to emerging market debt securities which are subject to restructurings or other similar actions. As a result, the rule change should promote the prompt and accurate clearance and settlement of the securities transactions.

EMCC has requested that the Commission approve the proposed rule change prior to the thirtieth day after publication of the notice of the filing. The Commission finds good cause for approving the rule change prior to the thirtieth day after publication of the notice of filing because approval to this proposed rule filing will allow EMCC to be prepared to take the appropriate actions wherever the next restructuring or similar event occurs which involves an EMCC eligible instrument.

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 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, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing will also be available for inspection and copying at the principal office of EMCC. All submissions should refer to File No. SR–EMCC–00–07 and should be submitted by February 1, 2001.

It is therefore ordered, pursuant to section 19(b)(2) of the Act,[5] that the proposed rule change (File No. SR–EMCC–00–07) be and hereby is approved.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[6]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–895 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43808; File No. EMCC–00–08]

Self-Regulatory Organizations; Emerging Markets Clearing Corporation; Notice of Filing of Proposed Rule Change to Permit Members to Satisfy Clearing Fund Obligations With Either Immediately Available Funds or Eligible Treasury Securities

January 4, 2001.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on November 3, 2000, the Emerging Markets Clearing Corporation (''EMCC'') filed with the Securities and Exchange Commission (''Commission'') the

[2] The Commission has modified the text of the summaries prepared by EMCC.

[3] 15 U.S.C. 78q–1(b)(3)(F).

[4] 15 U.S.C. 78q–1(b)(3)(F).

[5] 15 U.S.C. 78s(b)(2).

[6] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

proposed rule change as described in Items I, II, and III below, which items have been prepared primarily by EMCC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested parties.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change would allow EMCC members to satisfy their obligations to make additional clearing fund deposits with either immediately available funds, as currently required, or eligible treasury securities.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis, for, the Proposed Rule Change

In its filing with the Commission, EMCC included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it receive on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. EMCC has prepared summaries, set forth in sections (A), (B), and (C) below, of the most significant aspects of these statements.[2]

(A) Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

EMCC's Rule 4, section 5(iii) currently requires that members satisfy their obligation to make additional required deposits (''margin'') to the clearing fund in immediately available funds. EMCC Rule 4, section 8 permits the substitution of eligible collateral for clearing fund cash. On the same day a cash deposit is made, members may substitute eligible treasury securities[3] or an eligible letter of credit[4] for all or a portion of any such margin cash deposited provided the member maintains the requisite minimum ratios of cash to securities and/or letters of credit.[5]

To accommodate member requests, EMCC proposes changing Rule 4, section 5(iii) to allow members the option of meeting clearing fund margin calls with either cash or eligible treasury securities. The proposed rule change increases operating efficiencies by transforming what is currently a two-step process into a single step process. Eligible treasury securities so deposited would be valued at 96% of their current market value as provided in Section 8 of EMCC Rule 4. Notwithstanding the change, EMCC would retain the right, in its discretion, to require additional deposits to be made in cash.

EMCC believes that the proposed rule change is consistent with the requirements of section 17A of the Act[6] and the rules and regulations thereunder applicable to EMCC because it will promote operating efficiencies and will facilitate the prompt and accurate clearance and settlement of emerging market securities transactions.

(B) Self-Regulatory Organization's Statement on Burden on Competition

EMCC does not believe that the proposed rule change will have an impact on or impose a 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 relating to the proposed rule change have been solicited or received. EMCC will notify the Commission of any written comments received by EMCC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the **Federal Register** or within such longer period (i) as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consent, the Commission will:

(A) By order approve such proposed rule change or

(B) institute proceedings to determine whether the proposed rule change should be disapproved.

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 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 Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at the principal office of EMCC. All submissions should refer to File No. SR–EMCC–00–08 and should be submitted by February 1, 2001.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[7]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–896 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

[2] The Commission has modified the text of the summaries prepared by EMCC.

[3] As defined in EMCC Rule 1, the term ''eligible treasury security'' means an unmatured, marketable debt security in book-entry form that is a direct obligation of the United States Government.

[4] As defined in EMCC Rule 1, the term ''eligible letter of credit'' means a letter of credit that:

(a) Is issued by an approved letter of credit issuer;

(b) Contains the unqualified commitment of such issuer to pay a specified sum of money upon demand (properly drawn under the letter of credit) at any time prior to the expiration of the letter of credit;

(c) Is irrevocable and may be neither revoked nor amended to reduce its amount except upon the issuer's written notice to EMCC of its intent to revoke or amend, which must be given not less than five full business days prior to the date fixed for such revocation or amendment, and EMCC's consent to the revocation or amendment, which shall be given promptly upon EMCC's determination that the member either has substituted other collateral of at least equal value prior to such revocation or amendment or otherwise will have sufficient remaining value in its clearing fund deposit at the time of such revocation or amendment to satisfy its anticipated required fund deposit;

(d) States that (1) it will be duly honored upon presentment of it to the issuing bank and (2) partial drawings are permitted; and

(e) Is in a form and contains such other terms and conditions as may be required by EMCC.

[5] EMCC Rule 4, Sections 2 and 8(c).

[6] 15 U.S.C. 78q–1.

[7] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43793; File No. SR–GSCC–00–08]

Self-Regulatory Organizations; Government Securities Clearing Corporation; Notice of Filing of Proposed Rule Change Relating to Permitting Clearing Fund Offsets for Category 2 Dealer Netting Members and Futures Commission Merchants

January 3, 2001.

Pursuant to section 19(b)(1)[1] of the Securities Exchange Act of 1934 (''Act''), notice is hereby given that on July 31, 2000, the Government Securities Clearing Corporation (''GSCC'') 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 GSCC. 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 proposed rule change would enable GSCC to provide offsets in the clearing fund calculation for Category 2 Dealer Netting Members and Category 2 Futures Commission Merchants (''FCMs'') (collectively, ''category 2 members'') that meet all of GSCC's requirements for participating in its netting system.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, GSCC included statements concerning the purpose of and basis for the proposed rules change and discussed any comments it received on the proposed rules change. The text of these statements may be examined at the places specified in Item IV below. GSCC has prepared summaries, set forth in sections A, B and C below, of the most significant aspects of such statements.[2]

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

GSCC has established two membership categories (''category 1'' and ''category 2'') for dealers and FCMs that want to participate in GSCC's netting system. GSCC established a ''Category 2'' membership for dealers and FCMs that meet all of GSCC's requirements for participating in the netting system but have less net worth than GSCC's category 1 members. The minimum net worth requirement for category 1 members is $50 million, and the minimum net worth requirement for category 2 members is $25 million.[3]

While category 2 members have a lower net worth threshold than category 1 members, category 2 members currently have a more stringent clearing fund requirement under GSCC Rule 4, section 2(d). Specifically, the clearing fund requirement for category 2 members is calculated (i) without the benefit of any of the offsets across opposite net settlement positions[4] that are permitted for category 1 members and (ii) with margin factors set at the 99 percent-of-movements confidence level[5] (while margin factors for a category 1 member are set at the 95 percent confidence level). In addition, if a category 2 member elects to receive credit forward margin amounts[6] in its daily funds-only settlements, its margin factors are set at levels that are based on the greater of: (i) the category 2 margin factors or (ii) margin factors adjusted to reflect GSCC's historical two-day price volatility data covering 95 percent of all movements.[7]

GSCC currently has no active category 2 members. GSCC believes that certain entities that meet the eligibility requirements for category 2 membership and who recognize the many benefits of GSCC's netting system have not applied for membership because they consider the liquidity burden associated with the current clearing fund calculation to be too onerous. In order to broaden the availability of GSCC's netting services, GSCC proposes to allow for offsets in the clearing fund calculation for category 2 members. The current prohibition of offsets for category 2 members was implemented years ago as a conservative measure designed to avoid any risk arising from the creation of the category 2 level. Now, after many years of experience in conducting risk assessments, netting, and calculating margin, GSCC believes that prohibiting offsets is overly conservative and punitive. In addition, expanding the roster of GSCC netting members should also enhance the netting benefits for the existing members that currently trade with potential category 2 members.

Recognizing that category 2 members have smaller net worth bases and may therefore be deemed to pose a greater risk of default than category 1 members, the margin factors applied to category 2 members will continue to be set at the 99 percent confidence level (versus 95 percent for category 1 members). Furthermore, category 2 members will still be required to make an election regarding the receipt of forward margin. By permitting certain offsets for category 2 members and at the same time maintaining the more stringent margin factor requirements, GSCC will collect sufficient margin from duly approved category 2 members while expanding the range of netting members in a prudent manner.

GSCC believes that the proposed rule change is consistent with section 17A(b)(3)(F)[8] of the Act and the rules and regulations thereunder because it will (i) permit new entities to join GSCC and realize the benefits of participating in its netting system and (ii) enhance the netting benefits of existing members that currently trade with the potential members.

B. Self-Regulatory Organization's Statement on Burden on Competition

GSCC does not believe that the proposed rule change will have an impact or impose a burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change From Members, Participants or Others

Written comments relating to the proposed rule change have not yet been solicited or received.[9] GSCC will notify the Commission of any written comments received by GSCC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the **Federal**

[1] 15 U.S.C. 78s(b)(1).

[2] The Commission has modified the text of the summaries prepared by GSCC.

[3] Both categories have identical requirements for minimum excess net or liquid capital of $10 million.

[4] This means that GSCC does not allow category 2 members to offset long positions versus short positions.

[5] This means that the category 2 margin factors are based on GSCC's historical daily price volatility data covering 99 percent of all movements.

[6] A credit forward margin amount refers to GSCC's daily process of computing a member's collateral by marking to market the member's transactions that will settle in the future. The result will produce a net credit or a net debit. If the member has a net credit, it can elect to have GSCC pay it the value of the net credit. If the member has a net debit, it must pay GSCC.

[7] A category 2 member that elects to receive credit forward margin amounts will have higher margin factors than a category 2 member that does not make that election.

[8] 15 U.S.C. 78q–1(b)(3)(F).

[9] Members will be notified of the rule change filing, and comments will be solicited by an Important Notice.

Register or within such longer period (i) as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

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 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 in Washington, DC. Copies of such filing will also be available for inspection and copying at GSCC's principal office. All submissions should refer to File No. SR–GSCC–00–08 and should be submitted by February 1, 2001.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[10]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–897 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

[10] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43794; File No. SR–GSCC–00–10]

Self-Regulatory Organizations; Government Securities Clearing Corporation; Notice of Filing of Proposed Rule Change Relating to the Submission of Repo Collateral Substitutions

January 3, 2001.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] notice is hereby given that on September 11, 2000, the Government Securities Clearing Corporation (''GSCC'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change and on November 20, 2000, amended the proposed rule change as described in Items I, II and III below, which items have been prepared primarily by GSCC. The Commission is publishing this notice to solicit comments on the proposed rule change from interested parties.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The proposed rule change amends GSCC's rules relating to repo collateral substitutions processes and the fees associated with such substitutions.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, GSCC 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. GSCC has prepared summaries, set forth in section A, B, and C below, of the most significant aspects of these statements.[2]

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

Support of repo collateral substitutions has been an integral part of GSCC's array of services for blind-brokered repo markets since its introduction in 1996. Over the past two years, however, GSCC members have at times engaged in certain practices in connection with the repo collateral substitution process that present risk to GSCC and its members by placing an inordinate level of stress on the operational infrastructures of GSCC and its inter-dealer broker members, and by causing undue fail-financing expenses for other members. GSCC desires to prohibit these practices and to impose an additional risk management measure on the repo substitution process.

1. Late Notifications

Over the past two years, there have been an increasing number of occasions where GSCC experienced dramatic increases in the number of substitutions requests.[3] In addition, many members have not followed The Bond Market Association's (''TBMA'') published deadlines for substitution requests applicable to dealers and brokers which has resulted in GSCC receiving the substitution requests late in the day.[4] Specifically, some dealers are not complying with the substitution deadlines and some brokers, in turn, are not able to submit the requisite notifications to GSCC in a timely manner. The combination of the increased volume and the late submissions has, on certain occasions, placed an inordinate amount of stress on both GSCC's and the brokers' infrastructures. In addition, because ''new'' collateral is often delivered at or too near the close of the securities Fedwire to be redelivered by GSCC, GSCC is forced in many instances to obtain overnight financing, the cost of which is passed on to the netting members.[5]

GSCC has requested a number of times over the past two years that industry participants voluntarily comply with TBMA deadlines for

[1] 15 U.S.C. 78s(b)(1).

[2] The Commission has modified the text of the summaries prepared by GSCC.

[3] These spikes in substitution requests occur most often at month-end and quarter-end.

[4] Update 98–3 of the TBMA's Repo Trading Practices Guidelines (August 1996) (hereinafter ''TBMA's Guidelines'') states:

Unless the parties to a trade otherwise agree, in all trades executed through brokers, dealers should notify the brokers of any substitution of collateral *no later than 9:55 a.m. (New York Time).* In turn the broker should notify the counterparty dealer of the substitution by *10:00 a.m. (New York time).* Substitution notifications received after the relevant deadline will be accommodated on a *''best efforts''* basis. Additionally, dealers should provide brokers with the description of the substituted collateral by *11:00 a.m. (New York time).* (Emphasis in original.)

[5] GSCC's Rule 12 provides that the costs or expenses incurred by GSCC in obtaining financing under such circumstances are generally allocated pro rata among all netting members based upon usage of GSCC's services. Rule 12 also provide that if the GSCC Board determines that a netting member has on a frequent basis and without good cause caused GSCC to incur financing costs, the member can become obligated to pay for or reimburse GSCC for the entire amount of the financing costs.

submitting the requisite notifications for repo collateral substitution requests and that GSCC receive the notifications by or shortly after the 11:00 a.m. TBMA deadline by which the broker should have all requisite substitution information. There has not been sufficient compliance with these requests. Therefore, GSCC believes it is necessary to amend its rules to impose deadlines for the submission of the requisite notifications to GSCC.

Under the proposed rule change, GSCC will amend Rule 18 (''Special Provisions for Repo Transaction''), its Schedule of Timeframes, and its Fee Schedule to initially impose: (i) a deadline of noon (12 p.m.) after which the dealer member that initiated the substitution will be subject to a late fee of $500 per substitution notification and (ii) an absolute deadline of 12:30 p.m. after which GSCC will reject the substitution notification.[6] GSCC will extend these submission deadlines by one hour on those days that the TBMA announces in advance will be extraordinary volume days. All required information must be included in the notification in order for it to be deemed to be received by the imposed deadlines. Finally, substitution notifications or amendments thereto will no longer be accepted verbally but instead will only be accepted through the use of GSCC's designated messaging utility that is available to all repo netting participants.

2. Improper Use of Delivery Identification Codes

The other inappropriate practice in which members have been engaging with respect to the repo collateral substitution process involves the manner in which some members have been identifying the securities being delovered to GSCC. There are two codes that can be used to identify a securities delivery over the Fedwire: (i) A delivery code and (ii) a reversal code. The delivery code indicates to the receiver of the securities that the securities are being delivered to satisfy a ''pending receive'' obligation. The reversal code indicates that a delivery of securities has been rejected and is being sent back to the initiating party. (The industry terminology for this situations a ''DK,'' that is the receiver of the securities ''does not know'' transaction.)

There have been occasions where GSCC has received a securities delivery in relation to a repo collateral substitution before receiving the requisite substitution notification because members have been submitting the notifications to GSCC late in the day. Without the requisite notification, GSCC ''does not know'' the transaction for which the securities are being delivered and thus is forced to DK the securities. These securities eventually are redelivered to GSCC. However, many members have been redelivering the securities to GSCC using a reversal code instead of a delivery code.[7]

When GSCC receives a repo collateral substitution notification, it establishes a ''pending receive'' instruction on the clearing bank's system. The only automated way in which that ''pending receive'' may be satisfied is by securities identified by a delivery code. If the securities are sent using a reversal code, they will not automatically match the obligation that they are supposed to satisfy. A securities delivery identified by a reversal code appears from GSCC's point of view to be a DK of an original delivery (sent by GSCC) causing GSCC staff to have to research the reason for the DK. In instances where this process occurs near the close of the securities Fedwire, GSCC may be required to obtain overnight financing, the cost of which is usually borne by all members.

The proposed rules change revises Rule 12 (''Securities Settlement'') to make clear that the use of the reversal codes in the situation described above is improper and that members may not use a reversal code for a securities delivery obligation to GSCC unless the member has obtained GSCC's prior consent. Moreover, the proposed rule changes provide that, if GSCC is required to obtain overnight financing with respect to securities delivered in violation of this new rule, the entire amount of the financing cost will be borne by the offender. It should be noted that a member may continue to use a reversal code under circumstances where it wishes to indicate to GSCC (with GSCC as the initiating party of a securities delivery to the member) that it ''does not know'' the transaction. For example, if GSCC sends a securities delivery to a member in error, it is appropriate for the member to DK such delivery.

3. Prohibition of Substitutions Outside of GSCC

For risk management reasons, it is important to require that repo collateral substitutions with respect to repos that are in GSCC's net be made through GSCC. GSCC marks-to-market and establishes settlement obligations based on the transaction information underlying a repo transaction as it knows it. If a repo substitution occurs outside of GSCC, these calculations, which are vital for risk management purposes, will be incorrect. Therefore, GSCC proposes to change Rule 18 to add a requirement that all collateral substitutions with regard to repos that are on GSCC's books pending settlement must be made through GSCC.

4. Definition of a ''Repo Broker''

In order to accommodate proposed changes to Section 4 of Rule 18, which will permit a repo broker to submit a repo collateral substitution, GSCC is proposing to add the definition of repo broker to its definitions under Rule 1. A repo broker will be defined as an inter-dealer broker or a division or other separate operating unit within a dealer netting member that operates in the same manner as a broker and that participates in GSCC's repo netting service pursuant to the same requirements imposed under Rule 15 governing special provisions for certain netting members and Rule 19 governing special provisions for brokered repo transactions.

GSCC believes that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to GSCC and in particular with section 17A(b)(3)(F) of the Act because it will prohibit practices that are potentially harmful to GSCC's risk management process and operational infrastructure, and will result in undue financing costs for members.

B. Self-Regulatory Organization's Statement on Burden on Competition

GSCC does not believe that the proposed rule change will have an impact or impose a burden on competition.

C. Self-Regulatory Organization's Statement on comments on the Proposed rule Change Received From Members, Participants or Others

Written comments relating to the proposed rule change have not yet been solicited or received. GSCC will notify the Commission of any written comments received by GSCC.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Within thirty-five days of the date of publication of this notice in the **Federal Register** or within such longer period (i)

[6] The 12:00 p.m. deadline is one hour after which the broker should have received all of the requisite substitution information under TBMA guidelines. In the future, GSCC may change these deadlines depending on market practice. GSCC will notify its members of any changes in these timeframes in advance by an important notice.

[7] These members are, in effect, ''DK-ing'' a GSCC ''DK.''

as the Commission may designate up to ninety days of such date if it finds such longer period to be appropriate and publishes its reasons for so finding or (ii) as to which the self-regulatory organization consents, the Commission will:

(A) By order approve such proposed rule change, or

(B) Institute proceedings to determine whether the proposed rule change should be disapproved.

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 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 Section, 450 Fifth Street, NW., Washington, DC 20549. Copies of such filing also will be available for inspection and copying at GSCC's principle office. All submissions should refer to File No. SR–GSCC–00–10 and should be submitted by February 1, 2001.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[8]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–898 Filed 1–10–01; 8:45 am]

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[8] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43795; File No. SR–ISE–00–21]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the International Securities Exchange LLC, Relating to Marking Orders

January 3, 2001.

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 November 28, 2000, the International Securities Exchange LLC (''Exchange'' or ''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 Exchange. 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 Exchange proposes to amend ISE Rule 712 to provide that Members mark orders appropriately. The text of the proposed rule change is as follows. New text is italicized and deleted text is bracketed.

Rule 712. Submission *of Orders and* [for] Clearance *of Transactions*

(a) *Order Identification. When entering orders on the Exchange, each Member shall submit trade information in such form as may be prescribed by the Exchange in order to allow the Exchange to properly prioritize and match orders and quotations pursuant to Rule 713 and report resulting transactions to the Clearing Corporation.*

[(a)]*(b)* All transactions made on the Exchange shall be submitted for clearance to the Clearing Corporation, and all such transactions shall be subject to the rules of the Clearing Corporation. Every Clearing Member shall be responsible for the clearance of the Exchange Transactions of such Clearing Member and of each Member who gives up such Clearing Member's name pursuant to a letter of authorization, letter of guarantee or other authorization given by such Clearing Member to such Member, which authorization must be submitted to the Exchange.

[(b)]*(c)* On each business day at or prior to such time as may be prescribed by the Clearing Corporation, the Exchange shall furnish the Clearing Corporation a report of each Clearing Member's matched trades.

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 comments it received on the proposed rule change. 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

When entering an order on the Exchange, certain information, such as account type (*e.g.,* Public Customer or Firm Proprietary), must be indicated for the System to execute orders as specified in the Exchange's rules. Rather than relying upon ISE Rule 400 (Just and Equitable Principles of Trade) as the authority for the Exchange to conduct investigations and bring enforcement actions for misrepresenting trade information when entering orders, the Exchange proposes to adopt a rule specifying that Members are required to submit trade information to allow the Exchange to properly prioritize and match orders and quotations pursuant to the ISE Rule 713 (Priority of Quotes and Orders).

2. Statutory Basis

The basis under the Act for this proposed rule change is the requirement under section 6(b)(5)[3] 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 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 proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 15 U.S.C. 78f(b)(5).

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 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; (3) does not become operative for 30 days from the date of filing; and (4) the Exchange provided the Commission with written notice of its intent to file the proposed rule change at least five days prior to the filing date, the proposed rule change has become effective pursuant to section 19(b)(3)(A) of the Exchange Act [4] and Rule 19b–4(f)(6) [5] thereunder.

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 apropriate 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 submisssions 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 these 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'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–ISE–00–21 and should be submitted by February 1, 2001.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[6]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–792 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

[4] 156 U.S.C. 78s(b)(3)(A).

[5] 17 CFR 240.19b–4(f)6).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43799; International Series Release No. 1244; File No. SR–Phlx–00–111]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change by the Philadelphia Stock Exchange, Inc. To Amend Temporarily Rule 1063(a) and Options Floor Procedure Advices A–10 and C–1, Which Address Trading in Foreign Currency Options

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 January 2, 2001, the Philadelphia Stock Exchange, Inc. (''Phlx'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Phlx. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and to approve the proposal on an accelerated basis. By its terms, the proposed rule change will be effectively only until March 31, 2001.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The Phlx proposes to amend Phlx Rule 1063(a), Phlx Options Floor Procedure Advice A–10, and Phlx Options Floor Procedure Advice C–1. The proposed amendments would provide a temporary exception from the current requirement that a Registered Options Trader (''ROT'') be present at the trading post in certain circumstances. The exception is limited to foreign currency options (''FCOs'').The proposal would also make certain non-substantive stylistic changes to Floor Procedure Advices A–10 and C–1. The text of the proposed rule change is available at the principal office of the Phlx and at the Commission

[6] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b-4.

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 Phlx included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it had received on the proposal. The text of these statements may be examined at the places specified in Item IV below. The self-regulatory organization has prepared summaries, set forth in section 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 Phlx is seeking approval of temporary amendments to Phlx Rule 1063(a) (''Responsibilities of Floor Brokers''), Phlx Options Floor Procedure Advice A–10 (''Specialist Trading With Book''), and Phlx Options Floor Procedures Advice C–1 (''Ascertaining the Presence of ROTs in a Trading Crowd''), as discussed below. Phlx Rule 1063(a) currently provides Floor Brokers that at least one ROT is present at the trading post before representing an order for execution. Phlx Options Floor Procedure Advice A–10 currently provides that in any instance where a Specialist wishes to participate as principal in a trade with an order placed on that Specialist's book, the Specialist must ensure that at least one ROT is present in the trading crowd and is aware of the Specialist's intention to trade with the book both at the time of and immediately before the order's execution. Phlx Options Floor Procedure Advice C–1 currently provides that, before executing an options order, a Floor Broker representing the order shall ascertain that at least one ROT is present in the trading crowd at the post where the order is executed.

The Phlx has been advised that as of January 3, 2001, no ROTs will be doing business on a regular basis on the Phlx's Foreign Currency Options Floor ''FCO floor''),[3] although it is possible that, depending on the ROTs' business plans and objectives, a ROT may continue to do business on the FCO floor on a part-time basis during a transition period. The Phlx believes it is likely that there will be periods of time when FCO

[3] The Phlx's FCO trading floor is located in the same building as its equity options trading floor, but is in a different room.

Specialists and FCO Floor Brokers will be present on the FCO floor with no FCT ROTs present. The Phlx believes that compliance with Phlx Rule 1063(a) and Phlx Options Floor Procedure Advices A–10 and C–1 would not be possible under those circumstances.

The Phlx intends the proposed temporary rule change to provide an exception, effective until March 31, 2001, from the requirements in Phlx Rule 1063(a) and Phlx Options Floor Procedure Advices A–10 and C–1 that an ROT be present at the trading post in certain circumstances.[4] The Phlx represents that the exception would apply only if not ROT is present on the FCO floor when an FCO Specialist trades as principal with an order on the book, or when an FCO Floor Broker represents an order or executes a trade. The Phlx believes that the proposed temporary rule change would enable it to provide fair and orderly markets in FCOs in the event the FCO ROTs are absent from the FCO floor during the period that begins on the date of this Order and ends on March 31, 2001. The Phlx represents that, no later than January 12, 2001, it will file a proposed rule change seeking permanently to amend Phlx Rule 1063 and Phlx Floor Options Procedure Advices A–10 and C–1.

2. Statutory Basis

The Phlx believes that the proposed rule change is consistent with section 6(b) of the Act in general, and furthers the objectives of section 6(b)(5) in particular, in that it is designed to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, and processing information with respect to transactions in securities, to remove impediments to and perfect the mechanism of a free and open market system, and, in general, to protect investors and the public interest. Moreover, the Phlx believes that the proposed rule change is not designed to permit unfair discrimination between customers, issuers, brokers, or dealers. In the Phlx's view, the proposed rule change will permit Phlx Specialists to continue to trade as principal with orders on the book, and will allow Phlx Floor Brokers to continue to represent and execute orders in FCOs in the event that no ROTs are present on the FCO floor at any time from the date of this Order until March 31, 2001.

B. Self-Regulatory Organization's Statement on Burden on competition

The Phlx does not believe that the proposed rule change will impose any inappropriate burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants, or Others

The Phlx has neither solicited nor received written comments on the proposed rule change.

III. Commission's Findings and Order Granting Accelerated Approval of the Proposed Rule Change

The Commission has reviewed the Phlx's proposed rule change carefully and finds, for the reasons set forth below, that the proposal is consistent with the requirements of Section 6 of the Act and the rules and regulations thereunder applicable to a national securities exchange, particularly section 6(b)(5) of the Act.[5] The Commission believes that the proposed temporary rule change will enable the Phlx to provide fair and orderly markets in FCOs in the event that ROTs are absent from the FCO floor during the period beginning on the date of this Order and ending on March 31, 2001. Specifically, the Commission believes that, pursuant to the proposed temporary rule, Phlx Specialists will be able to trade as principals with FCO orders on the book and Phlx Floor Brokers will be able to represent and execute orders in FCOs at a time when the Phlx has been informed that ROTs no longer will be doing business on a regular basis on the FCO floor. In view of the foregoing, the Commission believes that the proposed rule change 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. Accordingly, the Commission finds that the proposed temporary rule change furthers the objectives of the Act.

The Phlx has requested that, pursuant to section 19(b)(2) of the act,[6] the Commission grant accelerated approval of the proposed rule change prior to the thirtieth day after the date of publication of notice of this filing in the **Federal Register**. The Commission finds good cause to approve the proposed temporary rule change effective immediately, so that Phlx Specialists and Floor Brokers may continue to operate in accordance with Phlx rules in the event that no ROTs are present on the FCO floor beginning January 3, 2001. The Commission expects that, no later than January 12, 2001, the Phlx will file a proposed rule change seeking permanently to amend Phlx Rule 1063 and Phlx Floor Options Procedure Advices A–10 and C–1.

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 office of the Phlx. All submissions should refer to File No. SR–Phlx–00–111 and should be submitted by February 1, 2001.

V. Conclusion

It Is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[7] that the proposed rule change (File No. SR–Phlx–00–111) is hereby approved on an accelerated basis and shall be in effect until March 31, 2001.[8]

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[9]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–791 Filed 1–10–01; 8:45 am]

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[4] The proposed temporary rule change also makes non-substantive changes to Phlx Rule 1063(a) and Phlx Options Floor Procedure Advices A–10 and Commission–1 by replacing the shorthand term ''ROT'' with the term ''Registered Options Trader.''

[5] 15 U.S.C. 78f(b)(5).

[6] 15 U.S.C. 78fs(b)(2).

[7] 15 U.S.C. 78s(b)(2).

[8] In approving the proposal, the Commission has considered the rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[9] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43790; International Series Release No. 1243; File No. SR–Phlx–00–66]

Self-Regulatory Organizations; Order Approving a Proposed Rule Change by the Philadelphia Stock Exchange, Inc., Relating to the Narrowing of the Exercise Strike Price Interval for Foreign Currency Options on the Euro

January 2, 2001.

I. Introduction

On July 12, 2000, pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] the Philadelphia Stock Exchange, Inc. (''Phlx'') filed with the Securities and Exchange Commission (''Commission'') a proposed rule change to reduce, from two cents to one cent, the strike price interval for foreign currency options on the Euro denominated in U.S. dollars (''Euro FCOs''). The proposed rule change and Amendment No. 1 thereto[3] were published for comment and appeared in the **Federal Register** on November 21, 2000.[4] The Commission received no comments on the proposal. This order approves the Phlx's proposed rule change, as amended.

II. Description of the Proposal

The Phlx proposes to adopt a narrower strike price interval with respect to American-style and European-style, standardized Euro FCOs with one, two, three, six, nine, and twelve months until expiration. Currently, Euro FCOs are listed at two-cent intervals. The Phlx proposes to reduce the exercise strike price interval of all Euro FCO series to one cent because the spot price of the Euro has declined against the U.S. dollar. For example, the Euro was worth $1.18738 in 1999, but was worth only $.8544 by October 2000.[5]

The Phlx's exercise strike price interval policies are administered pursuant to Phlx Rule 1012 (''Series of Options Open for Trading''). In accordance with Phlx Rule 1012, the Phlx lists regular and month-end Euro FCO contracts for each of the six expiration months. The Phlx currently lists Euro FCO contracts at two-cent strike price intervals; for example, it recently listed Euro FCOs at strike prices of $.80, $.82, $.84, $.86, $.88, and $.90 for each expiration month. The Phlx's adoption of the proposed one-cent exercise strike price interval would mean, in this example, that the additional strike prices of $.81, $.83, $.85, $.87, and $.89 would become available for trading in all six expiration months.

The Phlx represents that the purpose of the proposed rule change is to respond to customer demand for a narrower strike price interval as a result of a decline in the underlying price of the Euro as expressed in U.S. dollars. The Phlx believes that the proposed rule change makes economic sense because a narrower strike price interval in Euro FCOs would enable market participants to tailor their investment strategies more closely to the precise movement of the Euro. The Phlx notes that the Commission previously has permitted narrower exercise strike price intervals with respect to foreign currency options based on the market value of the respective underlying security.[6] The Phlx represents that it will distribute a memorandum to all of its members and FCO participants notifying them of the change in the exercise strike sprice interval for Euro FCO contracts, effective as of the date of Commission approval.[7]

The adoption of a narrower price interval for Euro FCOs would mean that additional Euro FCO series would become available for trading at the Phlx. The Phlx notes that its Selective Quoting Facility[8] would apply to all Euro FCO series traded. The Selective Quoting Facility provides that when the Phlx designates a particular foreign currency option series as a ''non-update strike.'' its quotes are not made avaialble for continuous dissemination to the public throughout the trading day. The Phlx believes that, by reducing the number of strike prices that are continuously updated and disseminated, the Selective Quoting Facility enables more timely and accurate quote displays of foreign currency options. Accordingly, the Phlx believes that the predicted increase in the number of Euro FCO series will not adversely affect its quote traffic and computer processing capacity.

III. Discussion

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules thereunder applicable to a national securities exchange, particularly section 6(b)(5) of the Act.[9] The Commission notes that the proposal is consistent with prior Commission orders approving narrow strike price intervals based upon the market values of the underlying securities.[10] Moreover, the Commission believes that the Phlx's proposal to adopt a one-cent strike price interval with respect to Euro FCOs will allow market participants to tailor their Euro FCO positions more finely and manage their currency risk with respect to the Euro more effectively. Accordingly, the Commission believes that the narrowing of the strike price interval for Euro FCOs will promote just and equitable principles of trade.

The Commission notes, however, that the narrowing of the strike price interval may disperse trading interest to a degree that excessively dilutes liquidity in open Euro FCO series. Therefore, in evaluating the appropriate strike price interval for the Euro FCOs, the Commission must weigh the presumed benefit of a wider array of investment opportunities against the potential hazard of a proliferation of illiquid options series. The Commission believes that the Phlx proposal strikes a reasonable balance between those competing concerns. Although the proposal will make additional Euro FCO series available for trading, the Commission expects the Phlx to continue its current policy of delisting options series with no open interest,[11]

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Amendment No. 1 superseded the original filing in its entirety. *See* letter from Richard S. Rudolph, Counsel, Phlx, to Nancy J. Sanow, Assistant Director, Division of Market Regulation, Commission, dated October 19, 2000.

[4] *See* Securities Exchange Act Release No. 43539 (November 9, 2000), 65 FR 69982.

[5] The Phlx previously traded options on the European Currency Unit (''ECU''), but delisted the product in July 1997 due to lack of open interest and trading activity. The Phlx reintroduced the ECU options in May 1998 with a two-cent strike price interval. *See* Securities Exchange Act Release No. 39940 (April 30, 1998), 63 FR 25258 (May 7, 1998) (SR–Phlx–98–17). This provided investors with an investment vehicle during the conversion from the ECU to the Euro, which occurred in January 1999. The Phlx began trading the Euro FCO in January 1999. *See* Securities Exchange Act Release No. 40953 (January 15, 1999), 64 FR 3734 (January 25, 1999) (SR–Phlx–99–01).

[6] *See* Securities Exchange Act Release No. 25685 (May 10, 1988), 53 FR 17524 (May 17, 1988) (Order approving narrower strike price intervals with respect to foreign currency options on the British pound denominated in U.S. dollars) (SR–Phlx–88–13); Securities Exchange Act Release No. 35631 (April 20, 1995), 60 FR 20544 (April 26, 1995) (Order approving narrower strike price interval with respect to foreign currency options on the French franc denominated in U.S. dollars) (SR–Phlx–95–06).

[7] Telephone conversation between Richard Rudolph, Counsel, Phlx, and Hong-Anh Tran, Special Counsel, Division of Market Regulation, Commission, on October 25, 2000.

[8] *See* Phlx Rule 1012, Commentary .04.

[9] 15 U.S.C. 78f(b)(5).

[10] *See* footnote 6, *supra.*

[11] *See* Securities Exchange Act Release No. 35631 (April 20, 1995), 60 FR 20544 (April 26, 1995) (Order approving narrower strike price intervals with respect to foreign currency options on the

Continued

thereby eliminating any illiquid Euro FCO series that may result from the implementation of this proposal.

Furthermore, because the Phlx will apply its Selective Quoting Facility to determine whether to disseminate the quotes of the additional Euro FCO series throughout the trading day, the Commission believes that the Phlx's computer system can manage the additional quote traffic that the new Eruo FCO options series are expected to generate. Nevertheless, the Commission requests that the Phlx monitor the volume of additional options series listed as a result of this rule change and ensure that the additional series do not adversely affect the computer system's processing capacity.

IV. Conclusion

It Is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[12] that the proposed rule change (File No. SR–Phlx–00–66) is approved.[13]

For the Commission, by the Division of the Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–793 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43792; File No. SR–Phlx–00–98]

Self-Regulatory Organizations; Order Granting Approval to Proposed By-Law Changes by the Philadelphia Stock Exchange, Inc. to Clarify References in the Exchange's By-Laws and Rules to the Allocation, Evaluation and Securities Committee

January 2, 2001.

I. Introduction

On November 7, 2000, the Philadelphia Stock Exchange, Inc. (''Phlx'' or ''Exchange'') filed with the Securities and Exchange Commission (''Commission''), pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4[2] thereunder, a proposed by-law change to clarify references in Exchanges by-laws and rules to the Allocation, Evaluation and Securities Committee. On November 29, 2000, the Commission published the proposal in the **Federal Register.**[3] The Commission received no comments on the proposal. This order approves the proposed by-law change.

II. Description of the Proposal

On July 5, 2000, the Commission approved a proposal to amend Phlx By-Law Article X, Section 10–7, to divide the Exchange's Allocation, Evaluation and Securities Committee into two separate committees: the Options Allocation, Evaluation and Securities Committee and the Equity Allocation, Evaluation and Securities Committee.[4] Currently, various sections of the Exchange's by-laws and rules refer simply to the ''Allocation, Evaluation and Securities Committee.'' Phlx proposes to amend its by-laws to clarify that references to the ''Allocation, Evaluation and Securities Committee'' in the Exchange by-laws and rules may mean either the Options Allocation, Evaluation and Securities Committee or the Equity Allocation, Evaluation and Securities Committee, as the context requires, and thus to ensure that the by-laws and rules pertaining to each committee remain consistent.

III. Discussion

The Commission has determined that the proposed rule change is consistent with the Act and the rules and regulations thereunder applicable to a national securities exchange.[5] In particular, the Commission finds that the proposal is consistent with section 6(b)(5) of the Act which requires, among other things, that the rules of an exchange be designed to foster cooperation and coordination with persons engaged in regulating and facilitating transactions in securities, to remove impediments to and perfect the mechanisms of a free and open market, and to protect investors and the public interest.[6] The Commission believes that in clarifying references to the Allocation, Evaluation and Securities Committee—which recently was split into two separate committees—the proposal will help ensure consistency in the Exchange's by-laws and rules which, therefore, furthers the purposes of the Act.

IV. Conclusion

It Is Therefore Ordered, pursuant to section 19(b)(2) of the Act,[7] that the proposed rule change (SR–Phlx–00–98) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[8]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 01–794 Filed 1–10–01; 8:45 am]

BILLING CODE 8010–01–M

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3310]

State of Alabama; Amendment #1

In accordance with notices received from the Federal Emergency Management Agency, dated December 22 and December 28, 2000, the above-numbered Declaration is hereby amended to include Cherokee and Jefferson Counties in the State of Alabama as a disaster area due to damages caused by severe storms and tornadoes, and to establish the incident period for this disaster as beginning on December 16, 2000 and continuing through December 22, 2000.

In addition, applications for economic injury loans from small businesses located in the following contiguous counties may be filed until the specified date at the previously designated location: Cleburne County, Alabama, and the counties of Chattooga, Floyd, and Polk in the State of Georgia. All other contiguous counties have been previously declared.

All other information remains the same, *i.e.,* the deadline for filing applications for physical damage is February 16, 2001 and for economic injury the deadline is September 18, 2001.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: January 3, 2001.

Herbert L. Mitchell,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 01–908 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

British pound denominated in U.S. dollars) (SR–Phlx–95–06).

[12] 15 U.S.C. 78s(b)(2).

[13] In approving the proposal, the Commission has considered the rule's impact on efficiency, competition, and capital formation. 15 U.S.C 78c(f).

[14] 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. 43585 (November 17, 2000), 65 FR 71193.

[4] *See* Securities Exchange Act Release No. 43011 (July 5, 2000), 65 FR 43069 (July 12, 2000) (File No. SR–Phlx–00–28).

[5] In approving this rule, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[6] 15 U.S.C. 78f(b)(5).

[7] 15 U.S.C. 78s(b)(2).

[8] 17 CFR 200.30–3(a)(12).

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3315]

State of Arkansas

As a result of the President's major disaster declaration on December 29, 2000, I find that the following Counties in the State of Arkansas constitute a disaster area due to damages caused by a severe winter ice storm beginning on December 12, 2000 and continuing: Arkansas, Benton, Bradley, Calhoun, Clark, Cleveland, Columbia, Crawford, Crittenden, Cross, Dallas, Desha, Drew, Faulkner, Franklin, Garland, Grant, Hempstead, Hot Spring, Howard, Jackson, Jefferson, Johnson, Lafayette, Lee, Lincoln, Little River, Logan, Lonoke, Madison, Miller, Mississippi, Monroe, Montgomery, Nevada, Ouachita, Perry, Pike, Poinsett, Polk, Prairie, Pulaski, Saline, Scott, Sebastian, Sevier, St. Francis, Union, Washington, White, Woodruff, and Yell. Applications for loans for physical damage as a result of this disaster may be filed until the close of business on February 27, 2001, and for loans for economic injury until the close of business on October 1, 2001 at the address listed below or other locally announced locations: U.S. Small Business Administration, Disaster Area 3 Office, 4400 Amon Carter Blvd., Suite 102, Fort Worth, TX 76155.

In addition, applications for economic injury loans from small businesses located in the following contiguous counties may be filed until the specified date at the above location: Ashley, Carroll, Chicot, Cleburne, Conway, Craighead, Independence, Lawrence, Newton, Phillips, Pope, and Van Buren Counties in Arkansas; Bossier, Caddo, Claiborne, Morehouse, Union, and Webster Counties, Louisiana; Bolivar, Coahoma, De Soto, and Tunica Counties in Mississippi; Adair, Delaware, Le Flore, McCurtain, and Sequoyah Counties, Oklahoma; Dyer, Lauderdale, Shelby, and Tipton Counties in Tennessee; Barry, Dunklin, McDonald, and Pemiscot Counties, Missouri; and Bowie and Cass Counties, Texas.

The interest rates are:

For Physical Damage:
Homeowners With Credit Available Elsewhere—7.000%
Homeowners Without Credit Available Elsewhere—3.500%
Businesses With Credit Available Elsewhere—8.000%
Businesses and Non-Profit Organizations Without Credit Available Elsewhere—4.000%
Others (Including Non-Profit Organizations) With Credit Available Elsewhere—7.000%
For Economic Injury:
Businesses and Small Agricultural Cooperatives Without Credit Available Elsewhere—4.000%

The number assigned to this disaster for physical damage is 331511. For economic injury the numbers are 9K1000 for Arkansas, 9K1100 for Louisiana, 9K1200 for Mississippi, 9K1300 for Oklahoma, 9K1400 for Tennessee, 9K1500 for Missouri and 9K1600 for Texas.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008.)

Dated: January 3, 2001.

Herbert L. Mitchell,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 01–902 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3304]

State of Michigan; Amendment #3

In accordance with information received from the Federal Emergency Management Agency, dated December 19, 2000, the above-numbered Declaration is hereby amended to extend the deadline for filing applications for physical damages as a result of this disaster to January 19, 2001.

All other information remains the same, *i.e.,* the deadline for filing applications for economic injury is July 17, 2001.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: December 27, 2000.

Allan I. Hoberman,

Acting Associate Administrator for Disaster Assistance.

[FR Doc. 01–906 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3311]

State of Mississippi (and Contiguous Counties in Alabama)

Lauderdale County and the contiguous counties of Clarke, Jasper, Kemper, Neshoba, and Newton in the State of Mississippi, and Choctaw and Sumter Counties in the State of Alabama constitute a disaster area due to damages caused by severe storms, damaging winds, and tornadoes that occurred on December 16, 2000. Applications for loans for physical damage as a result of this disaster may be filed until the close of business on February 23, 2001 and for economic injury until the close of business on September 24, 2001 at the address listed below or other locally announced locations: U.S. Small Business Administration, Disaster Area 2 Office, One Baltimore Place, Suite 300, Atlanta, GA 30308.

The interest rates are:

	Percent
For Physical Damage:	
Homeowners With Credit Available Elsewhere	7.000
Homeowners Without Credit Available Elsewhere	3.500
Businesses With Credit Available Elsewhere	8.000
Businesses and Non-Profit Organizations Without Credit Available Elsewhere	4.000
Others (Including Non-Profit Organizations) With Credit Available Elsewhere	7.000
For Economic Injury:	
Businesses and Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000

The numbers assigned to this disaster for physical damage are 331111 for Mississippi and 331211 for Alabama. For economic injury, the numbers are 9K0600 for Mississippi and 9K0700 for Alabama.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: December 22, 2000.

Aida Alvarez,

Administrator.

[FR Doc. 01–905 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Declaration of Disaster #3313]

State of New York; (and Contiguous Counties in New Jersey)

Rockland County and the contiguous counties of Orange and Westchester in the State of New York and Bergen and Passaic Counties in the State of New Jersey constitute a disaster area due to damages caused by a severe fire that occurred on December 11, 2000. Applications for loans for physical damage as a result of this disaster may be filed until the close of business on March 2, 2001 and for economic injury until the close of business on October 1, 2001 at the address listed below or other locally announced locations: U.S. Small Business Administration, Disaster Area 1 Office, 360 Rainbow Blvd., South 3rd Floor, Niagara Falls, NY 14303.

	Percent
For Physical Damage:	
Homeowners With Credit Available Elsewhere	7.000
Homeowners Without Credit Available Elsewhere	3.500
Businesses With Credit Available Elsewhere	8.000
Businesses and Non-Profit Organizations Without Credit Available Elsewhere	4.000
Others (Including Non-Profit Organizations) With Credit Available Elsewhere	7.000
For Economic Injury:	
Businesses and Small Agricultural Cooperatives Without Credit Available Elsewhere	4.000

The numbers assigned to this disaster for physical damage are 331305 for New York and 331405 for New Jersey. For economic injury, the numbers are 9K0800 for New York and 9K0900 for New Jersey.

(Catalog of Federal Domestic Assistance Program Nos. 59002 and 59008)

Dated: December 29, 2000.

Charles Payne,

Acting Administrator.

[FR Doc. 01–907 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

United Capital Investment Corporation; Notice of Surrender of License

Notice is hereby given that United Capital Investment Corporation, 450 Seventh Avenue, Suite 933, New York, New York 10123, has surrendered their license to operate as a small business investment company under the Small Business Investment Act of 1958, as amended (the Act). United Capital Investment Corporation was licensed by the Small Business Administration on February 5, 1985.

Under the authority vested by the Act and pursuant to the Regulations promulgated thereunder, the surrender was accepted on this date and accordingly, all rights, privileges, and franchises derived therefrom have been terminated.

(Catalog of Federal Domestic Assistance Program No. 59.11, Small Business Investment Companies)

Dated: January 3, 2001.

Don A. Christensen,

Associate Administrator for Investment.

[FR Doc. 01–903 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

SMALL BUSINESS ADMINISTRATION

[Delegation of Authority No. 23–C, Revision 4]

Inspector General; Delegation of Authority and Line of Succession

Delegation of authority No. 23–C is hereby revised to effect a delegation of authority and provide a line of succession from the Inspector General as follows:

I. Pursuant to authority vested in me by the Inspector General Act of 1978, as amended, in the event of the death, disability, absence, resignation, or removal of the Inspector General, Small Business Administration, the officials designated below, in the order indicated, and in the absence of the specific designation of another official in writing by the Inspector General or the Acting Inspector General, are hereby authorized to and shall serve as Acting Inspector General. The designated officials shall perform the duties and are delegated the full authority and power ascribed to the Inspector General by law and regulation as well as those authorities delegated to the Inspector General by the Administrator, Small Business Administration:

1. Deputy Inspector General
2. Counsel to the Inspector General
3. Assistant Inspector General for Auditing
4. Assistant Inspector General for Investigations
5. Assistant Inspector General for Inspection and Evaluation
6. Assistant Inspector General for Management and Policy

II. Anyone designated by the Inspector General as acting in one of the positions listed above remains in the line of succession; otherwise, the authority moves to the next position.

III. This delegation is not in derogation of any authority residing in the above officials relating to the operations of their respective programs, nor does it affect the validity of any delegations currently in force and effect and not specifically cited as revoked or revised herein.

IV. The authorities delegated herein may not be redelegated.

Dated: January 3, 2001.

Phyllis K. Fong,

Inspector General.

[FR Doc. 01–904 Filed 1–10–01; 8:45 am]

BILLING CODE 8025–01–P

DEPARTMENT OF STATE

[Public Notice 3535]

Bureau of Educational and Cultural Affairs; College and University Affiliations Program for Tunisia; Notice: Request for Grant Proposals

SUMMARY: The Office of Global Educational Programs of the Bureau of Educational and Cultural Affairs announces an open competition for an assistance award program to support the development of programs of instruction and faculty training at universities in Tunisia in business management, public administration, or another field with significant potential impact on the Tunisian economy. Accredited, post-secondary educational institutions meeting the provisions described in IRS regulation 26 CFR 1.501(c) may apply to pursue institutional or departmental objectives in partnership with one or more Tunisian institutions with support from the College and University Affiliations Program. The means for achieving the objectives of the applicant and its partner(s) may include mentoring, teaching, consultation, research, distance education, internship training, and professional outreach to public and private sector managers and entrepreneurs.

Overview and Project Objectives

The project is designed to assist Tunisian universities to develop a modern curriculum and program in business management or public administration to facilitate the development of business activity and the quality, efficiency and integrity of the private and public sectors in Tunisia. While priority will be given to competitive proposals in business management, proposals in public administration and other fields are also eligible if the proposals demonstrate their potential impact on the Tunisian economy.

Proposals emphasizing practical strategies to assist the Tunisian faculty and administrators to develop new curricula, teaching methodologies and programs are encouraged. All proposals should explain the potential impact of the project on the Tunisian economy.

Bureau policy stipulates that awards to organizations with less than four years' experience in conducting international exchanges are limited to $60,000. Funds will be awarded for a period up to three years to assist with the costs of exchanges, educational materials, and to increase library holdings and improve Internet connections. Up to 20% of the grant total may be used towards costs of

project administration. Indirect administrative costs are not an eligible expense for Bureau funding under this competition, but may be presented as part of the U.S. institutional contribution.

The project should pursue these objectives through a strategy that coordinates the participation of junior and senior level faculty, administrators or graduate students for any appropriate combination of teaching, mentoring, internships, in-service training and outreach, for exchange visits ranging from one week to an academic year. Visits of one semester or more for participants from Tunisia are strongly encouraged and program activities must be tied to the goals and objectives of the program. Proposals may also include English language training for selected participants whose existing English skills may need to be strengthened or refreshed.

U.S. Institution and Participant Eligibility

In the United States, participation in the program is open to accredited two and four-year colleges and universities, including graduate schools. Applications from consortia or other combinations of U.S. colleges and universities are eligible. Secondary U.S. partners may include governmental and non-governmental organizations, as well as non-profit service and professional organizations. The lead U.S. university in the consortium or other combination of cooperating institutions is responsible for submitting the application. Each application must document the lead organization's authority to represent all U.S. cooperating partners.

Participants representing the U.S. institution must be U.S. citizens. With the exception of outside consultants reporting on the degree to which project objectives have been achieved, participants who are traveling under the Bureau's grant funds must be teachers, advanced graduate students who are teaching or research assistants, or administrators from the participating institution(s). Advanced graduate students are eligible for Bureau-funded participation in this program only if they are working under the direction of an accompanying faculty participant.

Tunisian Institution and Participant Eligibility

In Tunisia, the partner must be a recognized institution of post-secondary education. Secondary foreign partners may include relevant governmental and non-governmental organizations, as well as non-profit service and professional organizations concerned with issues in business development or public administration training in Tunisia.

Foreign participants must be citizens or permanent residents of Tunisia and must be qualified to receive a J–1 visa.

Budget Guidelines

Applicants may submit a budget proposing up to $120,000 for funding by the Bureau. Requests for amounts smaller than the maximum are eligible. Budget and budget notes should carefully justify the amounts needed. There must be a summary budget as well as a breakdown reflecting the program and administrative budgets including unit costs. Cost sharing will be considered an important indicator of institutional commitment. Please refer to the Solicitation Package for complete guidelines and formatting instructions.

Announcement Title and Number

All correspondence with the Bureau of Educational and Cultural Affairs concerning this RFGP should reference the above title ''College and University Affiliations Program in Tunisia'' and reference number ECA/A/S/U–01–19.

FOR FURTHER INFORMATION CONTACT: Contact the Humphrey Fellowships and Institutional Linkages Branch, Office of Global Educational Programs, Bureau of Educational and Cultural Affairs; ECA/A/S/U, Room 349, SA–44; U.S. Department of State, 301 4th Street, SW., Washington, DC 20547, phone (202) 619–5289, fax: (202) 401–1433, e-mail: mpizarro@pd.state.gov to request a Solicitation Package.

The Solicitation Package contains detailed award criteria, required application forms, and guidelines for preparing proposals, including specific criteria for preparation of the proposal budget. Please specify the above reference number on all inquiries and correspondence.

Please read the complete **Federal Register** announcement before sending inquiries or submitting proposals. Once the RFGP deadline has passed, Bureau staff may not discuss this competition with applicants until the proposal review process has been completed.

To Download a Solicitation Package Via Internet

The entire Solicitation Package may be downloaded from the Bureau's website at http://exchanges.state.gov/education/rfgps. Please read all information before downloading.

Deadline of Proposals

All proposal copies must be received at the Bureau of Educational and Cultural Affairs by 5 p.m. Washington DC time on Friday, April 20, 2001. Faxed documents will not be accepted at any time. Documents postmarked by the due date but received on a later date will not be accepted.

It is the responsibility of each applicant to ensure compliance with the deadline.

Approximate Program Dates

Grants should begin on or about August 1, 2001.

Duration

August 1, 2001–August 31, 2004.

Submissions

The U.S. institutional partner must submit the proposal. Applicants must follow all instructions in the Solicitation Package. The original and 10 copies of the application should be sent to: U.S. Department of State, SA–44, Ref.: ECA/A/S/U–01–19, Program Management, ECA/EX/PM, Room 534, 301 4th Street, SW., Washington, DC 20547.

All copies should include the documents specified under Tabs A through E in the ''Project Objectives, Goals, and Implementation'' (POGI) section of the Solicitation Package. The documents under Tab F of the POGI should be submitted with the original application and with one of the ten copies.

Proposals that do not follow RFGP requirements and the guidelines appearing in the POGI and PSI may be excluded from consideration due to technical ineligibility.

Applicants must also submit the ''Executive Summary'' and ''Proposal Narrative'' Sections of the proposal on a 3.5'' diskette, formatted for DOS. This material must be provided in ASCII text (DOS) format with a maximum line length of 65 characters. The Bureau will transmit these files electronically to the Public Affairs Section of the U.S. Embassy in Tunis for its review, with the goal of reducing the time it takes to get the Embassy's comments for the Bureau's grants review process.

Diversity, Freedom and Democracy Guidelines

Pursuant to the Bureau's authorizing legislation, projects must maintain a non-political character and should be balanced and representative of the diversity of American political, social, and cultural life. ''Diversity'' should be interpreted in the broadest sense and encompass differences including, but not limited to, ethnicity, race, gender, religion, geographic location, socio-economic status, and physical challenges. Applicants are strongly

encouraged to adhere to the advancement of this principle both in program administration and in program content.

Please refer to the review criteria under the ''Support for Diversity'' section for specific suggestions on incorporating diversity into the total proposal. Public Law 104–319 provides that ''in carrying out programs of educational and cultural exchange in countries whose people do not fully enjoy freedom and democracy,'' the Bureau ''shall take appropriate steps to provide opportunities for participation in such programs to human rights and democracy leaders of such countries.'' Public Law 106—113 requires that the governments of the countries described above do not have inappropriate influence in the selection process. Proposals should reflect advancement of these goals in their program contents, to the full extent deemed feasible.

Review Process

The Bureau will acknowledge receipt of all proposals and will review them for technical eligibility. Proposals will be deemed ineligible if they do not fully adhere to the guidelines stated herein and in the Solicitation Package. All eligible proposals will be reviewed by the program office, as well as the Public Affairs Section of the U.S. Embassy in Tunis. Eligible proposals will be subject to compliance with Federal and Bureau regulations and guidelines and forwarded to Bureau grant panels for advisory review. Proposals may also be reviewed by the Office of the Legal Adviser or by other Department elements. Final funding decisions are at the discretion of the Department of State's Assistant Secretary for Educational and Cultural Affairs. Final technical authority for assistance awards (grants or cooperative agreements) resides with the Bureau's Grants Officer.

Review Criteria

State Department officers in Washington, D.C. and overseas will use the criteria below to reach funding recommendations and decisions. Technically eligible applications will be competitively reviewed according to the criteria stated below. These criteria are not rank-ordered or weighed.

1. Quality of the Program Idea

Proposals should exhibit originality, substance, precision, and resourcefulness. Proposals should exhibit sensitivity to the region, and have reasonable and feasible project objectives that are relevant to the needs of a Tunisian university. Proposals should describe projected benefits to the institutions involved as well as to wider communities of educators and practitioners in Tunisia.

2. Program Planning

Proposals should include creative, realistic and feasible program plans as well as a detailed schedule, which should include a well-reasoned combination of useful and appropriate mentoring, teaching techniques and outreach activities supporting the project objectives.

3. Support of Diversity

Proposals should demonstrate substantive support of the Bureau's policy on diversity by explaining how issues of diversity relate to project objectives and how these issues will be addressed during project implementation. Proposals should also outline the institutional profile of each participating institution with regard to issues of diversity.

4. Institutional Capacity and Commitment

Proposals should demonstrate significant understanding of the needs and capacities of the Tunisian university partner(s) as well as the needs and capacity of the U.S. institution, and should demonstrate a strong commitment to on-going cooperation during and after the period of the grant activity. Relevant factors include: the availability of a sufficient number of faculty and/or administrators willing and able to participate in project activities. Proposals should demonstrate a promise of long-term impact and a plan for follow-on activities.

5. Institutional Record/Ability

Proposals should demonstrate an institutional record of administering successful exchange programs, including responsible fiscal management and full compliance with all reporting requirements for past Bureau grants as determined by the State Department's contracts officers. The Bureau will consider the past performance of prior recipients and the demonstrated potential of new applicants. Reviewers will also consider the quality of exchange participants' academic credentials, skills, commitment and experience relative to the goals and activities of the project plan.

6. Project Evaluation

The proposal should outline a methodology to assess progress toward the achievement of project goals. The final evaluation should include an external component and observations about anticipated long-term impact on the Tunisian economy.

7. Cost-Effectiveness

Administrative and program costs should be reasonable and appropriate with cost sharing provided as a reflection of commitment to the pursuit of project objectives.

Authority

Overall grant making authority for this program is contained in the Mutual Educational and Cultural Exchange Act of 1961, Public Law 87–256, as amended, also known as the Fulbright-Hays Act. The purpose of the Act is ''to enable the Government of the United States to increase mutual understanding between the people of the United States and the people of other countries * * *; to strengthen the ties which unite us with other nations by demonstrating the educational and cultural interests, developments, and achievements of the people of the United States and other nations * * * and thus to assist in the development of friendly, sympathetic and peaceful relations between the United States and the other countries of the world.'' The funding authority for the program cited above is provided through the U.S. North African Economic Partnership.

Notice

The terms and conditions published in this RFGP are binding and may not be modified by any Bureau representative. Explanatory information provided by the Bureau that contradicts published language will not be binding. Issuance of the RFGP does not constitute an award commitment on the part of the Government.

The Bureau reserves the right to reduce, revise, or increase proposal budgets in accordance with the needs of the program and the availability of funds. Awards made will be subject to periodic reporting and evaluation requirements.

Notification

Final awards cannot be made until funds have been appropriated by Congress, allocated and committed through internal Bureau procedures.

Dated: January 2, 2001.

William B. Bader,

Assistant Secretary for Educational and Cultural Affairs, U.S. Department of State.

[FR Doc. 01–746 Filed 1–10–01; 8:45 am]

BILLING CODE 4710–05–U

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Docket No. MC–F–20975]

Stagecoach Holdings plc and Coach USA, Inc., et al.-Control-B & B Bus Corporation, Inc., et al.

AGENCY: Surface Transportation Board, Transportation.

ACTION: Notice tentatively approving finance application.

SUMMARY: Stagecoach Holdings plc (Stagecoach), and its subsidiary, Coach USA, Inc. (Coach), both noncarriers that control motor passenger carriers, and various subsidiaries of each (collectively, applicants), filed an application under 49 U.S.C. 14303 for Stagecoach, related applicants, Coach, and Coach's wholly owned subsidiary, Coach USA Northeast, Inc. (Coach Northeast), to acquire control of twenty-four New Jersey-based motor passenger carriers (New Jersey Carriers),[1] which hold federally issued operating authority to provide charter and special operations between points in the United States.[2] Persons wishing to oppose the application must follow the rules at 49 CFR 1182.5 and 1182.8. The Board has tentatively approved the transaction, and, if no opposing comments are timely filed, this notice will be the final Board action.

DATES: Comments must be filed by February 26, 2001. Applicants may file a reply by March 12, 2000. If no comments are filed by February 26, 2001, this notice is effective on that date.

ADDRESSES: Send an original and 10 copies of any comments referring to STB Docket No. MC–F–20975 to: Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, NW., Washington, DC 20423–0001. In addition, send one copy of comments to applicants' representative: Betty Jo Christian, Steptoe & Johnson LLP, 1330 Connecticut Avenue, NW., Washington, DC 20036.

FOR FURTHER INFORMATION CONTACT: Beryl Gordon, (202) 565–1600. (TDD for the hearing impaired: 1–800–877–8339.)

SUPPLEMENTARY INFORMATION: Stagecoach is a public limited company organized under the laws of Scotland, and Coach is a Delaware corporation. Stagecoach and its subsidiaries currently control Coach and its noncarrier regional management subsidiaries, as well as the motor passenger carriers jointly controlled by Coach and the management subsidiaries.[3]

Applicants state that, in June 2000, Coach purchased all of the outstanding stock of nineteen of the New Jersey Carriers, and acquired five additional carriers in that transaction by virtue of the fact that some of the nineteen carriers had wholly owned subsidiaries. Simultaneously with the purchase, Coach established five independent voting trusts, and placed 20% of the stock of each of the twenty-four New Jersey Carriers into each of the five separate voting trusts, to ensure no unlawful control of the carriers pending Board approval of the application.

Applicants submit that the federal and state operating authorities held by the New Jersey Carriers will not be transferred from one entity to another as a result of the control transaction, and that there will be no change in the operations of any of the New Jersey Carriers.

Under 49 U.S.C. 14303(b), we must approve and authorize a transaction we find consistent with the public interest, taking into consideration at least: (1) The effect of the transaction on the adequacy of transportation to the public; (2) the total fixed charges that result; and (3) the interest of affected carrier employees.

Applicants have submitted the information required by 49 CFR 1182.2, including information to demonstrate that the proposed transaction is consistent with the public interest under 49 U.S.C. 14303(b). Specifically, applicants have shown that the proposed transaction will have a positive effect on the adequacy of transportation to the public and will result in no increase in fixed charges, and no changes in employment. *See* 49 CFR 1182.2(a)(7). Additional information, including a copy of the application, may be obtained from the applicants' representative.

On the basis of the application, we find that the proposed transaction is consistent with the public interest and should be authorized. If any opposing comments are timely filed, this finding will be deemed vacated and, unless a final decision can be made on the record as developed, a procedural schedule will be adopted to reconsider the application. *See* 49 CFR 1182.6(c). If no opposing comments are filed by the expiration of the comment period, this decision will take effect automatically and will be the final Board action.

Board decisions and notices are available on our website at: ''WWW.STB.DOT.GOV.''

This decision will not significantly affect either the quality of the human environment or the conservation of energy resources.

It is ordered:

1. The proposed acquisitions of control are approved and authorized, subject to the filing of opposing comments.

2. If timely opposing comments are filed, the findings made in this decision will be deemed as having been vacated.

3. This decision will be effective on February 26, 2001, unless timely opposing comments are filed.

4. A copy of this notice will be served on: (1) the U.S. Department of Transportation, Federal Motor Carrier Safety Administration—MC–RI, 400 Virginia Avenue, SW., Suite 600, Washington, DC 20024; (2) the U.S. Department of Justice, Antitrust Division, 10th Street & Pennsylvania Avenue, NW., Washington, DC 20530; and (3) the U.S. Department of Transportation, Office of the General Counsel, 400 7th Street, SW., Washington, DC 20590.

Decided: January 4, 2001.

By the Board, Chairman Morgan, Vice Chairman Burkes, and Commissioner Clyburn.

Vernon A. Williams,

Secretary.

[FR Doc. 01–954 Filed 1–10–01; 8:45 am]

BILLING CODE 4915–00–P

[1] The twenty-four motor passenger carriers are: B & B Bus Corporation, Inc. (MC–233189), Cisko Bus Co., Inc. (MC–22072), D'Arcangelo Bus Co., Inc. (MC–168603), E & A Bus Co., Inc. (MC–168561), Elizabeth Bus Company (MC–168567), Gilsam Bus Company, Inc. (MC–233195), Independent Bus Company, Inc. (MC–168548), J & J Bus Company, Inc. (MC–168563), J & J Transit, Inc. (MC–233193), J & L Bus Co., Inc. (MC–168602), Kaunas Bus Co., Inc. (MC–168549), M & J Bus Company, Inc. (MC–233197), Meadowlands Transit, Inc. (MC–168588), Minsol Bus Company, Inc. (MC–233198), Penn-Mall Transit, Inc. (MC–208153), R & W, Inc. (MC–168547), R & W Transit, Inc. (MC–233186), Road Runner Tours, Inc. (MC–168623), Seven Bus Corporation (MC–233196), South Orange Avenue Bus Association (MC–168650), South Orange Avenue Bus Company, Inc. (MC–168569), Superior Bus Co., Inc. (MC–168622), Vailsburg Bus Co., Inc. (MC–165416), and WJB Company, Inc. (MC–233200).

[2] Each of the carriers also holds New Jersey intrastate authority. The operations of the carriers consist primarily of regular-route intrastate operations in northern New Jersey and occasional interstate charter operations.

[3] *See Stagecoach Holdings plc-Control-Coach USA, Inc., et al.*, STB Docket No. MC–F–20948 (STB served July 22, 1999).

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33978]

Summit View, Inc.—Acquisition of Control Exemption—Pittsburgh Industrial Railroad, Inc.

Summit View, Inc. (Summit), a noncarrier holding company, has filed a notice of exemption to acquire control, through stock purchase of the Pittsburgh Industrial Railroad, Inc. (PIRR), a Class III rail carrier, operating in the State of Pennsylvania.[1] PIRR is a wholly owned subsidiary of Railtex, Inc.[2]

The transaction was scheduled to be consummated on or shortly after December 19, 2000.

Summit currently controls seven existing Class III rail carriers: Ohio Central Railroad, Inc.; Ohio Southern Railroad, Inc.; Austintown Railroad, Inc.; Warren & Trumbull Railroad; Columbus & Ohio River Railroad Company, Ohio Pennsylvania Railroad Company, and Youngstown Belt Railroad Company.

Summit states that: (i) The railroads do not connect with each other; (ii) the transaction is not part of a series of anticipated transactions that would connect the railroads with each other; and (iii) the transaction does not involve a Class I carrier. Therefore, the transaction is exempt from the prior approval requirements of 49 U.S.C. 11323. *See* 49 CFR 1180.2(d)(2).

Under 49 U.S.C. 10502(g), the Board may not use its exemption authority to relieve a rail carrier of its statutory obligation to protect the interests of its employees. Section 11326(c), however, does not provide for labor protection for transactions under sections 11324 and 11325 that involve only Class III rail carriers. Because this transaction involves Class III rail carriers only, the Board, under the statute, may not impose labor protective conditions for this transaction.

If the 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 will not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 33978, must be filed with the Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, N.W., Washington, DC 20423–0001. In addition, a copy of all pleadings must be served on Kelvin J. Dowd, Esq., Slover & Loftus, 1224 Seventeenth Street, N.W.,Washington, DC 20036.

Board decisions and notices are available on our website at *http://WWW.STB.DOT.GOV.*

Decided: January 4, 2001.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 01–735 Filed 1–10–01; 8:45 am]

BILLING CODE 4915–00–P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

Proposed Extension of Information Collection; Comment Request

AGENCY: Office of the Comptroller of the Currency (OCC), Treasury.

ACTION: Notice and request for comment.

SUMMARY: The OCC, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on a continuing information collection, as required by the Paperwork Reduction Act of 1995. Currently, the OCC is soliciting comment concerning its extension of an information collection titled, ''Community Development Corporation and Project Investments and Other Public Welfare Investments—12 CFR 24.''

DATES: You should submit written comments by March 12, 2001.

ADDRESSES: You should direct all written comments to the Public Information Room, Office of the Comptroller of the Currency, Mailstop 1–5, Attention: 1557–0194, 250 E Street, SW., Washington, DC 20219. In addition, you may send comments by facsimile transmission to (202) 874–4448, or by electronic mail to regs.comments@occ.treas.gov. You can inspect and photocopy the comments at that address. You can make an appointment to inspect the comments by calling (202) 874–5043.

FOR FURTHER INFORMATION CONTACT: You can request additional information from or obtain a copy of the collection from Jessie Dunaway, OCC Clearance Officer, or Camille Dixon, (202) 874–5090, Legislative and Regulatory Activities Division (1557–0194), Office of the Comptroller of the Currency, 250 E Street, SW., Washington, DC 20219.

SUPPLEMENTARY INFORMATION: The OCC is proposing to extend OMB approval of the following information collection:

Title: Community Development Corporation and Project Investments and Other Public Welfare Investments—12 CFR 24.

OMB Number: 1557–0194.

Description: This submission covers an existing regulation and involves no change to the regulation or to the information collections embodied in the regulation. This regulation implements 12 U.S.C. 24 (Eleventh) which authorizes national banks to make investments that are designed primarily to promote the public welfare, including the welfare of low-and moderate-income families and communities (such as through the provision of housing, services, or jobs) consistent with safe and sound banking practices. The statute requires the OCC to limit a national bank's investment in any one project as well as its aggregate investment in such projects. This regulation requires national banks to make occasional filings to the OCC regarding investment proposals, certain self-certifications, and requests from 3-rated banks to self-certify.

The OCC is providing national banks with a form by which they make these filings and notify the OCC of investments authorized by 12 U.S.C. 24 (Eleventh). National banks must use this form either to self-certify an investment, pursuant to 12 CFR 24.5(a), or to submit a request for prior OCC approval of an investment, pursuant to 12 CFR 24.4(a) and 24.5(b). The OCC's form simplifies the self-certification and prior approval processes by outlining the rule's requirements and allowing banks to check off most responses. This streamlining of information that national banks must submit to the OCC helps to reduce the time and burden attendant to the rule's notification and approval processes. The OCC intends that this form will encourage banks to increase or enhance their investments under part 24.

A national bank that is not eligible to self-certify investments under 12 CFR 24.2(e), but is at least adequately capitalized and has a composite rating of at least 3 with improving trends under the Uniform Financial Institutions Rating System, may continue to submit a letter to the OCC's Community Development Division

[1] *See Pittsburgh Industrial Railroad, Inc.—Acquisition and Operation Exemption—Consolidated Rail Corporation and the Pittsburgh, Chartiers and Youghiogheny Railway Company,* STB Finance Docket No. 33308 (STB served Dec. 27, 1996).

[2] *See Railtex, Inc.—Continuance in Control Exemption—Pittsburgh Industrial Railroad, Inc.,* STB Finance Docket No. 33309 (STB served Dec. 27, 1996).

requesting the authority to self-certify investments, pursuant to 12 CFR 24.5(a)(4). The bank may also use the OCC's form to request prior OCC approval of its investments.

The information collection requirements in 12 CFR part 24 are located as follows:

Self certification of public welfare investments (12 CFR 24.5(a)): To self-certify an investment, an eligible bank shall submit a letter of self-certification to the OCC, within 10 days after it makes an investment.

Letters from 3-rated banks requesting to self-certify (12 CFR 24.5(a)(4)): A national bank that is not an eligible bank but that is at least adequately capitalized, and has a composite rating of at least 3 with improving trends under the Uniform Financial Institutions Rating System, may submit a letter to the OCC requesting authority to self-certify investments.

Investments requiring prior approval (12 CFR 24.5(b)): If a national bank does not meet the requirements for self-certification set forth in part 24, the bank must submit a proposal to the OCC requesting prior approval for an investment.

Type of Review: Extension of a currently approved collection.

Affected Public: Businesses or other for-profits.

Estimated Number of Respondents: 204.

Estimated Total Annual Responses: 204.

Frequency of Response: On occasion.

Estimated Total Annual Burden: 408 burden hours.

An agency may not conduct or sponsor, and a respondent is not required to respond to an information collection unless the information collection displays a currently valid OMB control number.

Comments submitted in response to this notice will be summarized and included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on:

(a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information has practical utility;

(b) The accuracy of the agency's estimate of the burden of the collection of information;

(c) Ways to enhance the quality, utility, and clarity of the information to be collected;

(d) Ways to minimize the burden of the collection on respondents, including through the use of automated collection techniques or other forms of information technology; and

(e) Estimates of capital or startup costs and costs of operation, maintenance, and purchase of services to provide information.

Dated: January 5, 2001.

Mark J. Tenhundfeld,

Assistant Director, Legislative & Regulatory Activities Division.

OCC's Form for Processing National Bank Community Development (Part 24) Investments

National banks may make investments designed primarily to promote the public welfare under the community development investment authority in 12 USC 24 (Eleventh) and its implementing regulation, 12 CFR 24 (Part 24). Part 24 contains the OCC guidelines to determine whether an investment is designed primarily to promote the public welfare and procedures that apply to these investments. National banks must submit the completed Form to self-certify or request prior approval of a public welfare investment.

Please provide the following information about the investing bank.

Bank name and charter:	Address:
Telephone number:	
Facsimile number:	
E-mail address/URL:	

Please indicate the process that the bank requests.

____Self-certification (12 CFR 24.5(a)) complete sections 1 and 2.

____Prior approval (12 CFR 24.5(b)) complete section 2.

Section 1 '' Self-Certification Only (12 CFR 24.5(a))

1. Please respond to the following questions to determine whether the bank is eligible to self-certify its Part 24 investments (12 CFR 24.2 (e)).

a. Is the bank ''well-capitalized,'' as defined in 12 CFR 6.4(b)(1)?

____Yes

____No (please answer question 1e.)

b. Does the bank have a composite rating of 1 or 2 under the Uniform Financial Institutions Rating System?

____Yes

____No (please answer question 1e.)

c. What was the bank's most recent Community Reinvestment Act rating?

____Outstanding

____Satisfactory

____Other (please answer question 1e.)

d. Is the bank under a cease and desist order, consent order, formal written agreement, or Prompt Corrective Action directive?

____Yes (please answer question 1e.)

____No

e. Has the OCC provided written notification that the bank may submit Part 24 self-certifications or otherwise be treated as an ''eligible bank'' for the purposes of Part 24?

____Yes (Please attach a copy of the OCC's written notification.)

____No (This investment cannot be self-certified. Please either: (a) send a letter to the OCC to request authorization to self-certify; or (b) complete section 2 to request prior OCC approval).

2.Please respond to the following questions about the bank's investment to determine whether the bank may self-certify its Part 24 investments (12 CFR 24.4(a) and 24.5(a)(5)):

a. Does the bank's aggregate outstanding investments under Part 24 exceed 5 percent of its capital and surplus?

____Yes (This investment cannot be self-certified. Please complete section 2 to request prior OCC approval.)

____No

b. Does this investment involve properties carried on the bank's books as ''other real estate owned''?

____Yes (This investment cannot be self-certified. Please complete section 2 to request prior OCC approval.)

____No

c. Has the OCC determined, in published guidance, that this investment type is inappropriate for self-certification? [For information about such investments, please refer to the most recent OCC Directory of National Bank Community Development Investments, visit the OCC's web page (http://www.OCC.treas.gov), or contact the OCC's

Community Development Division (202) 874–4930).]

____Yes (This investment cannot be self-certified. Please complete section 2 to request prior OCC approval.)

____No

(To continue the self-certification process or to request prior OCC approval, please proceed to section 2 of this Form.)

Section 2—All Requests

1. Please indicate the following about the bank's investment:

a. The name of the CDC, CD project, or entity into which the bank's investment has been or will be made. _____

b. The date on which the subject investment was or will be made.

_____

c. The type of investment (debt or equity).

_____

2. Please indicate how the bank's investment is consistent with Part 24 requirements for investment limits under 12 CFR 24.5.

a. Dollar amount of the bank's investment that is the subject of this submission: $ _____

b. Dollar amount of the bank's aggregate outstanding Part 24 investments (include this investment): $ _____

c. Bank's capital and surplus: $ _____ (Please indicate date _____.)

d. Percentage of the bank's capital and surplus represented by the aggregate outstanding Part 24 investments and commitments (include this investment) _____ %

e. Does this investment expose the bank to unlimited liability?

____ Yes (This investment cannot be made under Part 24.)

____No (Please explain in question 4b.)

3. Please indicate how the bank's investment is consistent with Part 24 requirements for public welfare investments under 12 CFR 24.3(a):

a. Check at least one of the following that benefits primarily from the bank's investment:

____ Low- and moderate-income individuals.

____ Low- and moderate-income areas.

____ Areas targeted for redevelopment by local, state, tribal, or federal government (including federal enterprise communities and federal empowerment zones).

b. Please identify at least one of the following activities that the bank's investment provides or supports:

____ Affordable housing, community services, or permanent jobs for low- and moderate-income individuals.

____ Equity or debt financing for small businesses.

____ Area revitalization or stabilization.

____ Other activities, services, or facilities that primarily promote the public welfare.

4.Please attach a brief description of the bank's investment. (See 12 CFR 24.5(a)(2)(iii) and (b)(2)(iii)). Include the following information in the description:

a. The activity or activities of the entity in which the bank has or will invest. (See examples of investment activities described in 12 CFR 24.6(a)).

b. Explain how the investment does not expose the bank to unlimited liability, such as by describing the structure of the investment (*e.g.,* CDC subsidiary, multibank CDC, multi-investor CDC, limited partnership, limited liability company, community development bank) and by providing any other relevant information.

c. The total funding for the project from all sources, if known.

d. The geographic area served by the investment entity.

e. Any community development partners involved in the project (*e.g.,* government or public agencies, nonprofits, other investors), if known.

f. Supplemental information (*e.g.,* prospectus, annual report, web address that contains information on the entity in which the investment is made), if available.

5.Please identify the type(s) of nonbank community support for or participation in the investment. (See 12 CFR 24.3(b)):

____ Representation on the board of directors by nonbank community representatives with expertise relevant to the proposed investment.

____ Establishment of an advisory board for the bank's community development activities that includes nonbank community representatives with expertise relevant to the proposed investment.

____ Formation of a formal business relationship with a community-based organization for the proposed investment.

____ Contractual agreements with community partners to provide services for the proposed investment.

____Joint ventures with local small businesses in the proposed investment.

____Financing for the proposed investment from the public sector or community development organizations or the receipt of federal low-income housing tax credits by the project in which the investment is made (directly or through a fund that invests in such projects).

____Other (please describe).

_____

_____

_____

6. Contact for additional information:

Name:

_____

Title:

_____

Address:

_____

Telephone number:

_____

Facsimile number:

_____

E-mail Address:

_____

7. Certification

The undersigned hereby certifies that the foregoing information in this Form is accurate and complete and that this investment complies with the requirements of 12 CFR 24.3 and 24.4 and does not expose the bank to unlimited liability. It is further certified that the undersigned is the bank's authorized representative for Part 24 investments.

_____

Name

_____

Title

_____

Signature

_____

Date

[FR Doc. 01–839 Filed 1–10–01; 8:45 am]

BILLING CODE 4810–33–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0578]

Proposed Information Collection Activity: Proposed Collection; Comment Request

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: The Veterans Health Administration (VHA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed reinstatement, without change, of a previously approved collection for which approval has expired, and allow 60 days for public comment in response to the notice. This notice solicits comments on information needed to determine the appropriate payment for medical care rendered to Vietnam Veterans' children who have spina bifida.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before March 12, 2001.

ADDRESSES: Submit written comments on the collection of information to Ann Bickoff, Veterans Health Administration (191A1), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. Please refer to ''OMB Control No. 2900–0578'' in any correspondence.

FOR FURTHER INFORMATION CONTACT: Ann Bickoff at (202) 273–8310.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995 (Public Law 104–13; 44 U.S.C., 3501—3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VHA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VHA's functions, including whether the information will have practical utility; (2) the accuracy of VHA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: Provision of Health Care to Vietnam Veterans' Children with Spina Bifida.

OMB Control Number: 2900–0578.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: The information collected will be used to determine appropriate payment for medical care rendered to Vietnam veterans' children with spina bifida. Without the information, VA will be unable to determine the correct amount to reimburse providers for their services.

Affected Public: Business or Other For-Profit and Individuals or Households.

Estimated Total Annual Burden: 1,584 hours.

Estimated Average Burden Per Respondent: 8 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 12,000.

Dated: December 1, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–818 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0583]

Proposed Information Collection Activity: Proposed Collection; Comment Request

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: The Veterans Health Administration (VHA) is announcing an opportunity for public comment on the proposed collection of certain information by the agency. Under the Paperwork Reduction Act (PRA) of 1995, Federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed reinstatement, without change, of a previously approved collection for which approval has expired, and allow 60 days for public comment in response to the notice. This notice solicits comments on the information needed to ensure that patients have sufficient information to provide informed consent for medical procedures.

DATES: Written comments and recommendations on the proposed collection of information should be received on or before March 12, 2001.

ADDRESSES: Submit written comments on the collection of information to Ann Bickoff, Veterans Health Administration (191A1), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420. Please refer to ''OMB Control No. 2900–0583'' in any correspondence.

FOR FURTHER INFORMATION CONTACT: Ann Bickoff at (202) 273–8310.

SUPPLEMENTARY INFORMATION: Under the PRA of 1995 (Public Law 104–13; 44 U.S.C., 3501—3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. This request for comment is being made pursuant to Section 3506(c)(2)(A) of the PRA.

With respect to the following collection of information, VHA invites comments on: (1) Whether the proposed collection of information is necessary for the proper performance of VHA's functions, including whether the information will have practical utility; (2) the accuracy of VHA's estimate of the burden of the proposed collection of information; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or the use of other forms of information technology.

Title: Regulation for Informed Consent for Patient Care (Title 38 CFR 17.32).

OMB Control Number: 2900–0583.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: The information collection subject to this rulemaking concerns the disclosure requirements that non-VA physicians contracting to perform services for VA must follow in conducting informed consent procedures. The information provided is designed to ensure that the patients (or in some cases, others) have sufficient information to provide informed consent.

Affected Public: Individuals or Households.

Estimated Total Annual Burden: 60,000 hours.

Estimated Average Burden Per Respondent: 15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 240,000.

Dated: December 1, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–819 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–NEW]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Health Administration (VHA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–NEW.''

SUPPLEMENTARY INFORMATION:

Titles: a. Application for Furnishing Nursing Home Care to Beneficiaries of Veterans Affairs, VA Form 10–1170.

b. Residential Care Home Program—Sponsor Application, VA Form 10–2407.

OMB Control Number: 2900–NEW.

Type of Review: New Collection.

Abstract: VA medical centers and VA Central Office use the information on the forms to determine non-Federal nursing home or the residential care home qualifications for providing care to veterans.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on March 9, 2000, at pages 12626 and 12627.

Affected Public: Not-for-profit institutions, Individuals or households, Business or other for-profit.

Estimated Annual Burden:

a. VA Form 10–1170—167 hours.

b. VA Form 10–2407—83 hours.

Estimated Average Burden Per Respondent:

a. VA Form 10–1170—20 minutes.

b. VA Form 10–2407—5 minutes.

Frequency of Response: One time.

Estimated Number of Respondents:

a. VA Form 10–1170—500.

b. VA Form 10–2407—1,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–NEW'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–820 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0002]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0002.''

SUPPLEMENTARY INFORMATION:

Title: Income-Net Worth and Employment Statement, VA Form 21–527.

OMB Control Number: 2900–0002.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: VA Form 21–527 is used to solicit income, net worth, and employment information. The information is used to determine eligibility and benefit rates for veteran's disability pension and compensation based on individual unemployability.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on September 14, 2000, at pages 55678–55679.

Affected Public: Individuals or households.

Estimated Annual Burden: 104,440 hours.

Estimated Average Burden Per Respondent: 60 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 104,440.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0002'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–821 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0018]

Agency Information Collection Activities Under OMB Review

AGENCY: Office of General Counsel, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Office of General Counsel (OGC), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0018.''

SUPPLEMENTARY INFORMATION:

Titles: a. Application for Accreditation as Service Organization Representative, VA Form 21.

b. Appointment of Individual as Claimant's Representative, VA Form 22a.

OMB Control Number: 2900–0018.

Type of Review: Reinstatement, with change, of a previously approved collection for which approval has expired.

Abstract: VA Form 21 will be used to obtain basic information necessary to

determine whether an individual may be accredited as a service organization representative for purposes of representation of claimants before VA. The information will be used by VA to evaluate qualifications, ensure against conflicts of interest, and allow appropriate organization officials to certify the character and qualifications of applicants.

VA Form 22a will be used by a claimant for VA benefits to confer power of attorney upon an attorney or agent in order that the attorney or agent may represent the claimant in proceedings before VA. The information is necessary for determining whether access to claimant records may be provided and for notification purposes.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on December 2, 1999, at pages 67625 and 67626.

Affected Public: Individuals or households, Business or other for-profit and Not-for-profit institutions and State, Local or Tribal Government.

Estimated Annual Burden: 2,775 hours.

a. VA form 21—275 hours.

b. VA Form 22a—2,500 hours.

Estimated Average Burden Per Respondent: 30 minutes.

a. VA form 21—15 minutes.

b. VA Form 22a—15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 11,100.

a. VA Form 21—1,100.

b. VA Form 22a—10,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0018'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–822 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0176]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0176.''

SUPPLEMENTARY INFORMATION:

Title: Monthly Record of Training and Wages, VA Form 28–1905c.

OMB Control Number: 2900–0176.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: A trainer uses the form as an outline for recording veterans' progress toward their rehabilitation goals as well as recording veterans' on-job training monthly wages. Trainers report these wages on the form only at the beginning of the program and at any time the trainee's wage rate changes. Following a veteran's completion of a vocational rehabilitation program, the trainer submits the form to VA for review by the veteran's case manager.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on September 22, 2000, at page 57434.

Affected Public: Individuals or households, Business or other for-profit.

Estimated Annual Burden: 3,000 hours.

Estimated Average Burden Per Respondent: 15 minutes.

Frequency of Response: Monthly.

Estimated Number of Respondents: 12,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0176'' in any correspondence.

Dated: December 5, 2000.

By direction of the Secretary.

Barbara H. Epps,

Information Management Service.

[FR Doc. 01–823 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0219]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Health Administration (VHA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0219.''

SUPPLEMENTARY INFORMATION:

Titles:

a. Application for CHAMPVA Benefits, VA Form 10–10D.

b. CHAMPVA Claim Form, VA Form 10–7959A.

c. CHAMPVA—Other Health Insurance (OHI) Certification, VA Form 10–7959C.

d. CHAMPVA Potential Liability Claim, VA Form 10–7959D.

e. VA Spina Bifida Healthcare Benefits—Claim for Miscellaneous Expenses, VA Form 10–7959E.

OMB Control Number: 2900–0219.

Type of Review: Reinstatement, with change, of a previously approved collection for which approval has expired.

Abstract: The following forms are used by Civilian Health and Medical Program-VA (CHAMP–VA) and spina bifida claimants to claim reimbursement for medical care and by VA to determine eligibility, process claims, detect fraud and recover costs from third parties.

a. VA Form 10–10D is used to determine eligibility of persons applying for healthcare benefits under the CHAMPVA program.

b. VA Form 10–7959A is used to adjudicate claims for CHAMPVA.

c. VA Form 10–7959C is used to systematically obtain Other Health Insurance information and to correctly coordinate benefits among all liable parties.

d. VA Form 10–7959D is used to recover costs associated with healthcare services related to injury or illness caused by a third party.

e. VA Form 10–7959E is used by VA Spina Bifida Healthcare beneficiaries to claim payment or reimbursement for healthcare services and related travel expenses.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on June 7, 2000, at pages 36219 and 36220.

Affected Public: Individuals or households, Business or Other for-Profit.

Estimated Annual Burden: 60,600 hours.

a. VA Form 10–10D—1,500 hours.
b. VA Form 10–7959A—50,000 hours.
c. VA Form 10–7959C—10,333 hours.
d. VA Form 10–7959D—1,167 hours.
e. VA Form 10–7959E—1,600 hours.

Estimated Average Burden Per Respondent:

a. VA Form 10–10D—10 minutes.
b. VA Form 10–7959A—10 minutes.
c. VA Form 10–7959C—10 minutes.
d. VA Form 10–7959D—7 minutes.
e. VA Form 10–7959E—4 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 405,000.

a. VA Form 10–10D—9,000.
b. VA Form 10–7959A—300,000.
c. VA Form 10–7959C—62,000.
d. VA Form 10–7959D—10,000.
e. VA Form 10–7959E—24,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0219'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–824 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0335]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Health Administration, Department of Veterans Affairs

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Health Administration (VHA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0335.''

SUPPLEMENTARY INFORMATION:

Title: Dental Record Authorization and Invoice for Outpatient Services, VA Form 10–2570d.

OMB Control Number: 2900–0335.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: VA Form 10–2570d is used to serve the following multi-purposes: (1) VA authorization to the veteran to seek a private dentist for examination; (2) Fee dentist's record of examination findings; (3) Dentist's treatment plan and listing of services needed; (4) Listing of dentist's usual and customary fees for specific services involved in treatment plan; (5) VA review, verification and authorization of treatment to the fee dentist; (6) Dentist's certification of services completed; (7) VA's permanent record of treatment provided for veterans and statement of exhaustion of benefits, if indicated; VA's approval of dental services and total fees for payment; (8) Fiscal approval and certification of payment and amount. Without this information, veterans' dental treatment needs could not be identified, fees for services could not be established, the veterans could not receive treatment, and the fee dentist could not be reimbursed.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on December 23, 1999, at pages 72144 and 72145.

Affected Public: Business or other for Profit.

Estimated Annual Burden: 14,333 hours.

Estimated Average Burden Per Respondent: 20 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 43,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0335'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst Information Management Service.

[FR Doc. 01–825 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0376]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Health Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Health Administration (VHA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0376.''

SUPPLEMENTARY INFORMATION:

Title: Agent Orange Registry Code Sheet, VA Form 10–9009.

OMB Control Number: 2900–0376.

Type of Review: Reinstatement, with change, of a previously approved collection for which approval has expired.

Abstract: The Agent Orange Registry Code Sheet is used to obtain information from veterans during an interview with the examining physician and Agent Orange Coordinator or other designated personnel. The information obtained is encoded onto the code sheet and entered into a computerized Agent Orange Registry. The registry provides a mechanism to catalogue prominent symptoms, reproductive health, diagnoses and enables VA to communicate with Agent Orange veterans through newsletters. The newsletter informs veterans of any increased health risks resulting from exposure to dioxin or other toxic agents, research finding or new compensation policies.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on May 16, 2000, at pages 31209–31210.

Affected Public: Individuals or households.

Estimated Annual Burden: 1,833 hours.

Estimated Average Burden Per Respondent: 20 minutes.

Frequency of Response: One time.

Estimated Number of Respondents: 5,500.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0376'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–826 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0377]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0377.''

SUPPLEMENTARY INFORMATION:

Title: Claim for Repurchase of Loan, VA Form 26–8084.

OMB Control Number: 2900–0377.

Type of Review: Extension of a currently approved collection.

Abstract: VA Form 26–8084 is used and completed by the holder of a delinquent vendee account, which has been guaranteed by VA. The holder of a delinquent vendee account is legally entitled to repurchase of the loan by VA when the loan has been continuously in default for three months and the amount of the delinquency equals or exceeds the sum of two monthly installments.

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 **Federal Register** Notice with a 60-day comment period soliciting comments on this collection of information was published on August 25, 2000 at page 51901.

Affected Public: Business or other for-profit.

Estimated Annual Burden: 421 hours.

Estimated Average Burden Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 842.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0377'' in any correspondence.

Dated: December 22, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–827 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0432]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810

Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0432.''

SUPPLEMENTARY INFORMATION:

Title: Invitation, Bid, and/or Acceptance or Authorization, VA Form 26–6724.

OMB Control Number: 2900–0432.

Type of Review: Extension of a currently approved collection.

Abstract: The form is used to solicit competitive bids; serves as a work order for repair of properties acquired by VA; serves as a record of contractor bids, VA acceptance of bids, inspection of completed work and contractor invoices and payments.

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 **Federal Register** notice with a 60-day comment period soliciting comments on this collection of information was published on September 14, 2000, at pages 55679–55680.

Affected Public: Business or other for profit.

Estimated Annual Burden: One (1) hour is being claimed for inventory purposes. The solicitation of bids is a common practice in the real estate management industry, and the submission of bids is routine with repair contractors.

Estimated Average Burden Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 60,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 12035, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0432'' in any correspondence.

Dated: December 1, 2000.

By direction of the Secretary:

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–828 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0518]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8135 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0518.''

SUPPLEMENTARY INFORMATION:

Title: Income Verification, VA Form 21–0161a.

OMB Control Number: 2900–0518.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: VA's compensation and pension programs require the accurate reporting of income by those who are in receipt of income-dependent benefits. VA Form 21–0161a solicits information from employers of beneficiaries who have been identified as having inaccurately reported their income to VA.

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 **Federal Register** notice with a 60-day comment period soliciting comments on this collection of information was published on August 31, 2000 at page 53092.

Affected Public: Business or other for-profit; Not-for-profit institutions; Farms; and State, Local, or Tribal Government.

Estimated Annual Burden: 57,000 hours.

Estimated Average Burden Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 114,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0518'' in any correspondence.

Dated: December 1, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–829 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0523]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0523.''

SUPPLEMENTARY INFORMATION:

Title: Loan Analysis, VA Form 26–6393.

OMB Control Number: 2900–0523.

Type of Review: Extension of a currently approved collection.

Abstract: The form is completed by representatives of lending institutions to determine the veteran-borrower's ability to qualify for a VA guaranteed loan. VA uses the information as evidence of the

lender's adherence to VA credit standards.

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 **Federal Register** notice with a 60-day comment period soliciting comments on this collection of information was published on September 14, 2000, at pages 55680–55681.

Affected Public: Business or other for profit.

Estimated Annual Burden: 100,000 hours.

Estimated Average Burden Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 200,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 12035, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0523'' in any correspondence.

Dated: December 1, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–830 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0567]

Agency Information Collection Activities Under OMB Review

AGENCY: National Cemetery Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the National Cemetery Administration (NCA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0567'' in any correspondence.

SUPPLEMENTARY INFORMATION:

Title: PMC Insert, VA Form 40–0247.

OMB Control Number: 2900–0567.

Type of Review: Reinstatement, without change, of a previously approved collection for which approval has expired.

Abstract: The purpose of the PMC Insert is to allow an eligible recipient, which includes the next of kin, other relatives or friends, *i.e.*, surviving spouses, sons, daughters, grandchildren, and others, to request additional certificates and/or replacements or corrected certificates upon receipt of the original PMC. Replacements are requested due to PMCs being bent, water soaked, or other damage during mail handling; corrected PMCs are requested due to an incorrect name of the deceased veteran. The PMC is a gold foiled-embossed certificate containing the Great Seal of the United States and bearing the President's signature. It is mailed to relatives and friends of deceased, honorably discharged veterans honoring their military service to our Nation. In most cases involving recent deaths, the local VA Regional Office originates the application process without request from the next of kin as part of processing death benefits claims.

The PMC Insert is not self-initiated by the general public/eligible recipients. There is no form or application that is used to initiate an original request. Original requests are normally in the form of letters and/or telephone calls from eligible recipients.

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 **Federal Register** notice with a 60-day comment period soliciting comments on this collection of information was published on August 31, 2000, at pages 53093 and 53094.

Affected Public: Individuals or households.

Estimated Annual Burden: 1,298 hours.

Estimated Average Burden Per Respondent: 2 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 38,952.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7613. Please refer to ''OMB Control No. 2900–0567'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–831 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

[OMB Control No. 2900–0577]

Agency Information Collection Activities Under OMB Review

AGENCY: Veterans Benefits Administration, Department of Veterans Affairs.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (PRA) of 1995 (44 U.S.C., 3501 *et seq.*), this notice announces that the Veterans Benefits Administration (VBA), Department of Veterans Affairs, has submitted the collection of information abstracted below to the Office of Management and Budget (OMB) for review and comment. The PRA submission describes the nature of the information collection and its expected cost and burden; it includes the actual data collection instrument.

DATES: Comments must be submitted on or before February 12, 2001.

FOR FURTHER INFORMATION OR A COPY OF THE SUBMISSION CONTACT: Denise McLamb, Information Management Service (045A4), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 273–8030 or FAX (202) 273–5981. Please refer to ''OMB Control No. 2900–0577.''

SUPPLEMENTARY INFORMATION:

Title: Spina Bifida Award Attachment Important Information, VA Form 21–0307.

OMB Control Number: 2900–0577.

Type of Review: Extension of a currently approved collection.

Abstract: The form is used to provide children of Vietnam veterans with Spina Bifida with information about VA health care and vocational training and gives steps they must take to apply for such benefits.

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 **Federal Register**

notice with a 60-day comment period soliciting comments on this collection of information was published on August 31, 2000, at page 53094.

Affected Public: Individuals or households.

Estimated Annual Burden: 500 hours.

Estimated Average Burden Per Respondent: 15 minutes.

Frequency of Response: On occasion.

Estimated Number of Respondents: 2,000.

Send comments and recommendations concerning any aspect of the information collection to VA's OMB Desk Officer, OMB Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 (202) 395–7316. Please refer to ''OMB Control No. 2900–0577'' in any correspondence.

Dated: November 28, 2000.

By direction of the Secretary.

Barbara H. Epps,

Management Analyst, Information Management Service.

[FR Doc. 01–832 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

Enhanced-Use Development at the Samuel S. Stratton VA Medical Center, Albany, New York

AGENCY: Department of Veterans Affairs.

ACTION: Notice of Designation and Notice of Intent to Execute an Enhanced-Use Lease.

SUMMARY: The Acting secretary of the Department of Veterans Affairs (VA) is designating the Samuel S. Stratton VA Medical Center, Albany, New York, as a site for Enhanced-Use lease development. VA intends to execute an Enhanced-Use lease of 2.5 acres to the Renaissance Corporation of America for construction of a 1,220-space parking garage.

FOR FURTHER INFORMATION CONTACT: Jake Gallun, Portfolio Manager, Asset and Enterprise Development Service (181B), Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 565–4307.

SUPPLEMENTARY INFORMATION: 38 U.S.C. Sec. 8161, *et seq.,* specifically provides that the Secretary may enter into an Enhanced-Use lease, if the Secretary determines that at least part of the use of the property under the lease will be to provide appropriate space for an activity contributing to the mission of the Department; the lease will not be inconsistent with and will not adversely affect the mission of the Department; and the lease will enhance the property. The project meets these requirements.

Dated: December 20, 2000.

Hershel W. Gober,

Acting Secretary of Veterans Affairs.

[FR Doc. 01–817 Filed 1–10–01; 8:45 am]

BILLING CODE 8320–01–M

Federal Register

Thursday,
January 11, 2001

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 431, 433, 435, etc.
State Child Health; Implementing Regulations for the State Children's Health Insurance Program; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 431, 433, 435, 436, and 457

[HCFA–2006–F]

RIN 0938–AI28

State Child Health; Implementing Regulations for the State Children's Health Insurance Program

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

ACTION: Final rule.

SUMMARY: Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP) . Title XXI provides funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, States must submit a State plan, which must be approved by the Secretary.

This final rule implements provisions related to SCHIP including State plan requirements and plan administration, coverage and benefits, eligibility and enrollment, enrollee financial responsibility, strategic planning, substitution of coverage, program integrity, certain allowable waivers, and applicant and enrollee protections. This final rule also implements the provisions of sections 4911 and 4912 of the BBA, which amended title XIX of the Act to expand State options for coverage of children under the Medicaid program. In addition, this final rule makes technical corrections to subparts B, and F of part 457.

DATES: This final rule is effective April 11, 2001. *Compliance dates:* To the extent contract changes are necessary, however, States will not be found out of compliance until the next contract cycle. By contract cycle, we mean the earlier of the date of the original period of the existing contract, or the date of any modification or extension of the contract (whether or not contemplated within the scope of the contract) .

FOR FURTHER INFORMATION CONTACT: Regina Fletcher for general information, (410) 786–3293; Diona Kristian for subpart A, State plan, (410) 786–3283; Judy Rhoades for subpart C, Eligibility, (410) 786–4462; Regina Fletcher for subpart D, Benefits, (410) 786–5916; Nancy Fasciano for subpart E, Cost sharing, (410) 786–4578; Kathleen Farrell for subpart G, Strategic planning, (410) 786–1236; Terese Klitenic for subpart H, Substitution of coverage, (410) 786–5942; Maurice Gagnon for subpart I, Program integrity (410) 786–60619; Cindy Shirk for subpart J, Allowable waivers, (410) 786–1304; Christina Moylan for subpart K, Applicant and enrollee protections (410) 786–6102; Judy Rhoades for Expanded coverage of children under Medicaid and Medicaid coordination, (410) 786–4462; Christine Hinds for Medicaid disproportionate share hospital expenditures, (410) 786–4578; and Joan Mahanes for the Vaccines for Children program, (410) 786–4583.

SUPPLEMENTARY INFORMATION: *Copies:* To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $9. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

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I. Background

Section 490l of the BBA, Public Law 105–33, as amended by Public Law 105–100, added title XXI to the Act. Title XXI authorizes the SCHIP program to assist State efforts to initiate and expand the provision of child health assistance to uninsured, low-income children. Under title XXI, States may provide child health assistance primarily for obtaining health benefits coverage through (1) a separate child health program that meets the requirements specified under section 2103 of the Act; (2) expanding eligibility for benefits under the State's Medicaid plan under title XIX of the Act; or (3) a combination of the two approaches. To be eligible for funds under this program, States must submit a State child health plan (State plan), which must be approved by the Secretary.

The State Children's Health Insurance Program is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to States on a matching basis for Federal fiscal years (FY) 1998 through 2007. At the Federal level, SCHIP is administered by the Department of Health and Human Services, through the Center for Medicaid and State Operations (CMSO) of the Health Care Financing Administration (HCFA). Federal payments under title XXI to States are based on State expenditures under approved plans effective on or after October 1, 1997.

This final rule implements the following sections of title XXI of the Act:

- Section 2101 of the Act, which sets forth the purpose of title XXI, the requirements of a State plan, State entitlement to title XXI funds, and the effective date of the program.
- Section 2102 of the Act, which sets forth the general contents of a State plan, including eligibility standards and methodologies, coordination, and outreach.
- Section 2103 of the Act, which contains coverage requirements for children's health insurance.
- The following parts of section 2105 of the Act: 2105(c)(2)(B), which relates to cost-effective community based health delivery systems; 2105(c)(3), which relates to waivers for purchase of family coverage; 2105(c)(5), which relates to offsets for cost-sharing receipts, and 2105(c)(7) which relates to limitations on payment for abortion.
- Section 2106 of the Act, which describes the process for submission and approval of State child health plans and plan amendments.
- Section 2107 of the Act, which sets forth requirements relating to strategic objectives, performance goals and program administration.

• Section 2108 of the Act, which requires States to submit annual reports and evaluations of the effectiveness of the State's title XXI plan.
• Section 2109 of the Act, which sets forth the relation of title XXI to other laws.
• Section 2110 of the Act, which sets forth title XXI definitions.

This final rule also implements the provisions of sections 4911 and 4912 of the BBA, that amended title XIX of the Act to provide expanded coverage to children under the Medicaid program. Specifically, section 4911 of the BBA set forth provisions for use of State child health assistance funds for enhanced Medicaid match for expanded eligibility under Medicaid to provide medical assistance to optional targeted low-income children. Section 4912 of the BBA added a new section 1920A to the Act creating a new option to provide presumptive eligibility for children. Both title XXI and title XIX statutory provisions are discussed in detail in section II. of this preamble.

This final rule also implements section 704 of the Balanced Budget Refinement Act of 1999 (BBRA, Public Law 106–113), enacted on November 29, 1999, which requires the Secretary to refer to the title XXI program as the ''State Children's Health Insurance Program'' or ''SCHIP'' in any publication or other official communication.

We note that on May 24, 2000, HCFA published in the **Federal Register** a final rule (HCFA 2114–F) concerning financial program allotments and payments to States under SCHIP at (65 FR 33616). In that rule, we implemented section 2104 and portions of section 2105 of the Act, which relate to allotments and payments to States under title XXI. For a detailed discussion of title XXI and related title XIX financial provisions, including the allotment process, the payment process, financial reporting requirements and the grant award process, refer to the May 24, 2000 final rule (65 FR 33616). Please note that, to eliminate duplication and provide clarity, this final rule also amends selected sections of the financial rule within Subpart B.

II. Provisions of the Proposed Rule and Discussion of Public Comments

A. Overview

1. Summary of Proposed Provisions and Significant Revisions in This Final Rule.

On November 8, 1999, we published a proposed rule that set forth the programmatic provisions of the State Children's Health Insurance Program (64 FR 60882). The provisions of the proposed regulation were largely based on previously released guidance, and therefore represented policies that had been in operation for some time. In the proposed rule, we identified a number of areas in which we elaborated on previous guidance or proposed new policies.

We received 109 timely comments on the proposed rule. Interested parties that commented included States, advocacy organizations, individuals, and provider organizations. The comments received varied widely and were often very detailed. We received a significant number of comments on the following areas: State plan issues, such as when an amendment to an existing plan is needed; information that should be provided or made available to potential applicants, applicants and enrollees; the exemption to cost sharing for American Indian/Alaska Native children; eligibility and ''screen and enroll'' requirements; Medicaid coordination issues; eligibility simplification options such as presumptive eligibility; the definition of a targeted low-income child; substitution of private coverage; data collection on race, ethnicity, gender and primary language; grievance and appeal procedures and other enrollee protections; and premium assistance for employer-sponsored coverage.

All public comments have been summarized and are discussed in detail in section II below. A brief summary of key issues discussed in the proposed rule as well as significant revisions made in this final rule follows:

• Subpart A—State Plan Requirements

The proposed regulation included several conditions under which States must submit amendments to approved SCHIP plans. For example, we proposed that a State must submit a plan amendment when the funding source of the State share changes, prior to such change taking effect. In addition, we proposed that amendments to impose cost sharing on beneficiaries, increase existing cost-sharing charges, or increase the cumulative cost-sharing maximum considered the same as amendments proposing a restriction in benefits. We noted that States would be required to follow rules regarding prior public notice and retroactive effective dates for these amendments.

The final regulation clarifies several issues surrounding the circumstances under which amendments must be submitted. It lists more clearly the program changes that must be included in the State plan by submitting an amendment. In addition, the final rule modifies the budget requirements to require a 1-year projected budget for those amendments that have a significant budgetary impact. Budgets are no longer required with every State plan amendment; however States must submit a 3-year projected budget with its annual report (discussed in subpart G). Finally, States must submit an amendment before making changes in the source of the non-Federal share of funding.

We have provided additional clarification with regard to the requirements for coordination between SCHIP and Medicaid, as well as coordination with other public programs. We have modified the regulation text to further emphasize the need for coordination with other public programs after screening for Medicaid eligibility during the SCHIP application process, as well as assisting in enrollment in SCHIP of children determined ineligible for Medicaid.

The section laying out provisions for enrollment assistance and information requirements has been modified to include the provision of linguistically appropriate materials to families of potential applicants, applicants and enrollees in SCHIP to assist them in making informed health care decisions about their health plans, professionals and facilities. We have also clarified that, in addition to information about the types of benefits and participating providers. In addition, States must inform applicants and enrollees about their rights and responsibilities regarding procedures for review of adverse decisions regarding eligibility or health services decisions and the circumstances under which they may be subject to enrollment caps and waiting lists.

• Subpart C—Eligibility, Screening, Applications and Enrollment

The proposed rule outlined provisions for eligibility and enrollment for separate child health programs and implementation of the ''screen and enroll'' requirement. It also included the title XXI restrictions on the participation of children of public agency employees who are eligible to participate in a State health benefits plan, children who are residing in institutions for mental disease (IMDs), and children who are inmates of public institutions.

The final rule further elaborates on issues surrounding eligibility, enrollment and ensuring that children eligible for Medicaid benefits are enrolled in Medicaid. We have modified the definition of ''targeted low-income child'' to parallel a modification to the definition of ''optional targeted low-

income child'' under the Medicaid regulations. This modification effectively excludes from title XXI ''maintenance of effort'' provisions certain section 1115 demonstrations that were in place on March 31, 1997, but that were so limited in scope that we do not consider them to be equivalent to Medicaid.

We clarified the standards for eligibility for separate child health programs, including: (1) Clearly permitting self-declaration of citizenship; (2) prohibiting durational residency requirements; (3) prohibiting lifetime caps or other time limits on eligibility; (4) permitting 12 months of continuous eligibility; and (5) permitting enrollment caps and waiting lists when approved as part of the State plan. In addition, we have specifically required States to implement standards for conducting eligibility determinations and a process that does not exceed 45 days (excluding days during which the application has been suspended).

The rule provides further clarification of the issues surrounding children of public employees, children in IMDs and children who are inmates of public institutions. For example, we clarified that the children of public employees are eligible only if the employer contribution under a State health benefits plan is no more than a nominal contribution of $10 per family, per month. We also modified the definition of ''State health benefits plan'' to exclude separately run county, city, or other public agency plans that receive no State contribution toward the cost of coverage and in which no State employees participate.

The final rule also further clarifies the requirements for treatment of children found to be potentially eligible for Medicaid after applying for coverage under a separate child health program. In order to ensure the effectiveness of the screening mechanisms, States are required to establish a system for monitoring the screen and enroll process. Finally, the rule lays out procedures for States that opt to provide presumptive eligibility for the separate child health program while the application and eligibility determination process is underway.

- Subpart D—Coverage and Benefits

The proposed rule provided for some flexibility for States in keeping the SCHIP benefit package current. A State using the benchmark benefit package option is not required to submit an amendment each time the benchmark package changes, as long as it continues to offer the same benefits covered under the approved State plan. However, States must submit an amendment to their State plan any time the benefits offered to enrollees change. If the change in benefits is intended to conform the separate State benefit package to the benchmark coverage, then the benefit package remains benchmark coverage. But if the change in benefits causes the State-offered benefits to differ from the benchmark coverage, then the benefits must be reclassified as benchmark equivalent or one of the other benefit package options.

The proposed rule included the requirement that States use the ''prudent layperson standard'' in defining coverage for emergency services under SCHIP. The proposed rule also required use of the American Committee on Immunization Practices (ACIP) schedule for age-appropriate immunizations.

The final rule retains all of the same provisions as included in the proposed rule. In addition, for purposes of clarity, we have moved a provision formerly found in Subpart G, Strategic Planning, Reporting, and Evaluation into this Subpart. The provision, entitled ''State assurance of access to care and procedures to assure quality and appropriateness of care'' includes the requirements for assuring access to covered services, including emergency services, well-baby, well-child and well-adolescent care, and age appropriate immunizations. This provision also requires States to assure appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition. Finally, this provision requires States to assure decisions related to the provision of health services are completed within 14 days of the request for the service, in accordance with the medical needs of the child.

- Subpart E—Enrollee Financial Responsibilities

Title XXI permits States to impose cost sharing on enrollees in separate child health programs, but places a 5 percent cap on the amount of cost-sharing expenditures for families with incomes greater than 150 percent of the Federal Poverty Level (FPL). In an attempt to preserve State flexibility, we proposed to give States the option to use either gross or net family income when calculating this cost-sharing cap for families. In addition, we proposed to place a limit of 2.5 percent on cost sharing for families with incomes at or below 150 percent of the FPL, in order to ensure that those families with lower incomes will not be required to spend the same percentage of their income on cost sharing as those with higher incomes. Many commenters supported the need for this distinction, given the more limited amount of disposable income in such families. Under the proposed rule, States also had the option to apply medical costs for non-covered or non-eligible family members toward the cumulative maximum cap.

We proposed that States must have a process in place that will protect enrollees by ensuring an opportunity to pay past due cost-sharing amount before they can be disenrolled from the program for failure to pay cost sharing. We suggested that States should look for a pattern of nonpayment, and provide clear notice and opportunities for late payment before taking action to disenroll.

Finally, title XXI includes provisions to ensure enrollment and access to health care services for American Indian and Alaska Native (AI/AN) children. The proposed regulation incorporated our interpretation that in light of the unique Federal relationship with tribal governments, cost-sharing requirements for individuals who are members of a Federally recognized tribe are not consistent with this statutory requirement.

The final rule clarifies that States must provide to the family of each individual SCHIP enrollee, the cumulative cost-sharing maximum amount for that year. In addition, this subpart confirms that the State plan must clearly describe a State's cost-sharing policy in terms of which children will be subject to cost sharing, the consequences for enrollees who do not pay a charge, and the disenrollment protections provided to enrollees in the event that they do not pay the cost sharing. States must also describe the methodology to ensure that families do not exceed the cumulative cost-sharing maximum and assure that families will not be held liable for cost-sharing amounts, beyond the copayment amounts in the State plan, for emergency services provided outside of an enrollee's managed care network.

The final rule confirms the protections included in the proposed rule related to AI/AN children and clarifies that States may use self-declaration of tribal membership for identifying AI/AN children in order to facilitate implementation of the cost-sharing exemption.

The final rule continues to require that States may not impose more than one type of cost sharing on a service; and that States may only impose one copayment based on the total cost of

services furnished during one office visit.

Finally, States must provide enrollees with an opportunity to show that their family income has declined before being disenrolled for failure to pay cost sharing, because the child may have become eligible for a category with lower or no cost sharing if family income has declined. States must also provide enrollees with an opportunity for an impartial review to address disenrollment from the program for this reason (see discussion of new Subpart K, Applicant and Enrollee Protections).

• Subpart G—Strategic Planning, Reporting and Evaluation

The proposed regulation included provisions intended to ensure compliance with the statute and the elements of the State's approved title XXI plan. This subpart included the essential elements of strategic objectives and performance measures to assist the States and the Federal government in assessing the effectiveness of the SCHIP program in increasing the number of children with health insurance, and an assessment of the quality of and access to needed health care services.

The proposed rule also outlined the quarterly statistical reporting requirements and the required elements of States annual reports and the March 31, 2000 SCHIP evaluation.

The final rule confirms these requirements and further describes data elements to be reported by the States, including data on gender, race, ethnicity, and primary language. The gender, race and ethnicity data will be required in the State's quarterly statistical enrollment reports; and the annual reports will include a description of data regarding the primary language of SCHIP enrollees. In addition, the annual reports will include an updated budget for a 3-year period, including any changes in the source of the non-Federal share of State plan expenditures. The annual reports must also include description of the State's current income eligibility standards and methodologies.

Finally, the final rule notes the Secretary's intention to develop, with input from States, academic and intergovernmental organizations, a core set of national performance goals and measures. When developed, States will also be required to report on these measures in their annual reports.

• Subpart H—Substitution of Coverage

The proposed rule set forth requirements for ensuring that States have in place mechanisms aimed at preventing substitution of public coverage for private group coverage. With respect to coverage provided directly through SCHIP, the preamble included a description of HCFA's three-tiered policy to apply increased scrutiny to States' substitution prevention strategies at higher incomes. For coverage provided through premium assistance for employers' group health plans, the proposed rule set forth specific requirements for a six-month period of uninsurance and a minimum 60 percent employer premium contribution.

Due to a general lack of evidence of the existence of substitution below 200 percent of the FPL and the significant number of comments received on this subpart, we have revised the final rule to clarify our policy related to substitution. The preamble to the final rule clarifies that for coverage provided other than through premium assistance programs, we will no longer require a substitution prevention strategy for families with incomes below 250 percent of the FPL. Instead, States will be required to monitor the occurrence of substitution below 200 percent of the FPL. Between 200 and 250 percent of the FPL, we will work with States to develop procedures, in addition to monitoring, to prevent substitution that would be implemented in the event that an unacceptable level of substitution is identified. Above 250 percent of the FPL, States must have a substitution prevention mechanism in place, however we encourage States to use other strategies than waiting periods.

For States wishing to utilize premium assistance programs, we have revised the final rule to provide additional flexibility. While we have retained the 6-month waiting period without group health plan coverage, States have flexibility to include a number of exceptions for circumstances such as involuntary loss of coverage, economic hardship, and change to employment that does not offer dependent coverage. We have also removed the requirement for States to demonstrate an employer contribution of at least 60 percent when providing coverage through premium assistance programs. Rather, we have clarified that States must demonstrate cost-effectiveness of their proposals by identifying a minimum contribution level and providing supporting data to show that the level is representative of the employer-sponsored insurance market in their State.

Finally, the final rule provides that the Secretary has discretion to reduce or waive the minimum period without private group health plan coverage.

• Subpart I—Program Integrity

The provisions in this subpart are intended to preserve program integrity in the State Children's Health Insurance Program. We proposed that States must have fraud and abuse protections in place, but provided flexibility to States in developing program integrity protections for separate child health programs. States with separate child health programs may utilize systems already existing for Medicaid, but are not required to do so. In addition, we proposed that States have additional flexibility in setting procurement standards more broadly than are available under Medicaid. We proposed that States may choose to base payment rates on public and/or private rates for comparable services for comparable populations, and where appropriate, establish higher rates in order to ensure sufficient provider participation and access.

Finally, the proposed regulation included various enrollee protections consistent with the President's directive regarding the *Consumer Bill of Rights and Responsibilities,* including provisions regarding grievances and privacy protections. In response to public comment about the need for consistency of provisions throughout the final rule, we have moved the overview of the enrollee protections to the preamble of this final rule, but have removed it from the final regulation text, as it repeated the protections included throughout the proposed rule. The discussion of enrollee protections is now found in subpart K—Applicant and Enrollee Protections.

The final rule confirms the significance of maintaining program integrity in SCHIP and clarifies issues related to the certification of data that determines payment and the development of actuarially sound payment rates. It notes that States should base payment rates on public and/or private rates for comparable services for comparable populations, consistent with the principles of actuarial soundness. We have also moved the subsection formerly entitled, ''Grievances and appeals'' to the new Subpart K, where these requirements are retained and elaborated upon.

Finally, the rule confirms the importance of maintaining the integrity of professional advice to enrollees by requiring compliance with the provisions of the final Medicare+Choice rule that prohibit interference with health care professionals' advice to enrollees; require that professionals provide information about treatment options in an appropriate manner; limits

physician incentive plans; and provides requirements related to information disclosure related to physician incentive plans.

• Subpart J—Waivers

The proposed rule noted the requirements for obtaining a waiver to provide coverage through a community-based delivery system and discussed the circumstances under which a State may obtain a waiver in order to provide title XXI coverage to entire families. We proposed that in order to qualify for a family coverage waiver, the State must meet several requirements, including a requirement that the proposal be cost-effective.

In the final rule, we have clarified that the provisions of this subpart apply to separate child health programs. The provisions apply to Medicaid expansions only in cases where the State files claims for administrative costs under title XXI and seeks a waiver of limitations on such claims for coverage under a community-based health delivery system. We have clarified that HCFA will review requests for waivers under this subpart using the same time frames (the 90-day review clock) as those used for the review of State plan amendments under SCHIP. In addition, in response to comments received on this subpart, we have extended the approval period for the waivers to provide coverage through a community based delivery system from two years to three years in an attempt to better align with the period of availability for SCHIP allotments.

With regard to the family coverage waiver, the final rule clarifies that when applying the cost-effectiveness test, States must assess cost-effectiveness in its initial request for a waiver, and then annually. States may do the assessment either on a case-by-case basis or in the aggregate.

• Subpart K—Applicant and Enrollee Protections

The proposed rule emphasized the importance of enrollee protections by including many of the elements of the Consumer Bill of Rights and Responsibilities throughout the rule. In addition, an overview of these protections was presented in Subpart I—Program Integrity and Beneficiary Protections. We received several comments on our decision to implement the CBRR through this regulation. While we have retained the protections included in the proposed rule in the appropriate location as related to the issue, we have attempted to clarify the required protections by creating a new subpart dedicated to privacy and a process for review of certain eligibility and health services matters, Subpart K—Applicant and Enrollee Protections.

We have included more specific requirements than those that were included in Subpart I of the proposed rule and will require the State plan to include a description of the State's process for review and resolution of eligibility and enrollment matters such as denial or failure to make a timely determination of eligibility, and suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. States must also provide enrollees with an opportunity for external review of health services matters, such as delay, denial, reduction, suspension or termination of health services, in whole or in part; and the failure to approve, furnish, or provide payment for health services in a timely manner. Exceptions to these requirements can be made in the event that the sole basis for such a decision is a change in the State plan or a change in Federal or State law that affects all or a group of applicants or enrollees without regard to their individual circumstances.

The final rule lays out requirements for the core elements of review of eligibility or health services matters, and requires that the reviews be impartial, conducted by a person or entity that has not been directly involved or responsible for the matter under review. The rule also establishes a 90-day time frame within which external reviews (or a combination of an internal and an external review) must be completed. States should take into consideration the medical needs of the patient when conducting the reviews and provide expedited time frames if an enrollee's physician determines that a longer time frame could seriously jeopardize the enrollees life, health or ability to attain or regain maximum function. If the enrollee has access to both internal and external review, each level of expedited review may take no more than 72 hours.

The final rule requires States to provide continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. States must also provide enrollees with timely written notice of any determinations subject to review including the reasons for the determination, an explanation of applicable rights to review, the time frames for review, and circumstances under which enrollment may continue pending a review.

Finally, the rule provides an exception for States that operate premium assistance programs under SCHIP. If the State utilizes a premium assistance program that does not meet the requirements for review under this Subpart, the State must give applicants and enrollees the option to enroll in the non-premium assistance program in the State. States must provide this option at initial enrollment and at each renewal of eligibility.

• Expanded Coverage of Children under Medicaid and Medicaid Coordination.

In this section we set forth our changes to the Medicaid regulations that allow for expanded coverage of children under title XIX. Although these regulations are related to title XXI and SCHIP, they are changes to the Medicaid program and all existing Medicaid regulations also apply. We set forth requirements related to presumptive eligibility for children, the enhanced FMAP (Federal medical assistance percentage) rate for children, and the new group of optional targeted low-income children established by the statute. The presumptive eligibility provisions have been clarified in this final rule to lay out specific notification requirements and establish procedures for making presumptive eligibility determinations and expands the definition of ''qualified entity'' in accordance with the Benefits Improvement and Protection Act of 2000 (BIPA). Finally, the rule establishes consistent coordination requirements between Medicaid and SCHIP.

2. General Comments

In this section, we have summarized and responded to general public comments on the SCHIP programmatic regulation. These comments relate to the program or the proposed rule as a whole and not to any particular provision of the proposed rule. All other public comments are addressed below in the context of the relevant subpart.

Comment: We received a great number of comments discussing the issue of providing SCHIP coverage through premium assistance programs. Many commenters noted the difficulty that States would have in requiring employer plans to meet the proposed requirements. Many commenters argued that the proposed rule imposed too many requirements on SCHIP coverage obtained through employer-sponsored insurance and that the proposed provisions would stifle State innovation in utilizing such insurance.

Response: At the time of publication of the proposed rule, the experience with premium assistance programs in SCHIP had been limited to only a few States. Therefore, the proposed

regulation did not include a great deal of specificity regarding the regulation's applicability to premium assistance models. We have attempted to provide States with flexibility, while ensuring that States meet their statutory obligation to all SCHIP enrollees regardless of the insurance product being provided. Further, it would not be consistent with the SCHIP statute to exempt certain enrollees from the protections established by law, simply because of the delivery model. However, we also recognize the value and the increased potential for reaching children associated with interaction with the employer-based insurance market. Thus, while we will ensure compliance with the protections set forth in this final rule, we look forward to working closely with States to help in the development and approval of proposals that utilize premium assistance programs. As noted in the overview section, we have provided some additional flexibility in subpart H, Substitution, with respect to premium assistance programs that we hope will facilitate increased use of premium assistance programs in SCHIP. We have also provided some flexibility with regard to certain enrollee protections in subpart K.

Comment: One commenter noted that there is an inequity in funding that disadvantages States that expanded eligibility prior to March 31, 1997. Another commenter indicted that it is difficult for States that had expanded Medicaid to high levels prior to March 31, 1997 to access SCHIP funds and suggested that States be allowed to use SCHIP funds to subsidize employer-sponsored insurance.

Response: We recognize the inequities that have been caused by the ''maintenance of effort'' provision in the SCHIP statute, which holds States to the current eligibility levels in effect on March 31, 1997, and we applaud States that were progressive in expanding their Medicaid programs through section 1115 demonstrations and through the flexibility provided under section 1902(r)(2) and section 1931 of the statute. However, the maintenance of effort provision in the SCHIP statute was put in place specifically to ensure that States did not roll back the eligibility and benefits standards that were in place prior to the existence of SCHIP, and to encourage further expansion in implementing States' SCHIP programs.

Comment: Several commenters asserted that the proposed regulations were overly prescriptive, limit State flexibility, and raise program administrative costs. Several commenters specifically complained that the proposed regulations appeared to push States toward Medicaid or Medicaid-like programs. Some commenters asserted that the overall approach directly contradicted Executive Order 13132 on Federalism. Some argued that the regulations should be limited to areas Congress specifically required the Secretary to address in regulations, the administrative review process for State plans, or to clarification of essential terms. While some commenters recognized the need for federal guidance, they supported the inclusion of such guidance in the preamble and other guidance documents rather than in the regulation text.

Response: In developing the proposed and final regulations, we have taken great care to try to balance the need to ensure that SCHIP will provide the full intended benefits to uninsured, low-income children with the goal of retaining as much State flexibility as possible. HCFA has tried to administer the program and develop policies in a manner that gives States a full opportunity to develop programs that met local needs, whether through a Medicaid expansion or a separate child health program.

To make it possible for States to develop and implement their programs, from the time of enactment of the SCHIP program, HCFA has worked with States to disseminate as much information as possible, as quickly as possible. In the first three months of the program's existence, we released over 100 answers to frequently asked questions and issued several policy guidance letters. We continue to take into consideration the changing needs of States. The programs that States developed vary in scope, delivery system and many other respects. The diversity and innovation that has been displayed is an indication that State flexibility does indeed exist.

In addition, we consulted with State and local officials in the course of the design and review stages of State proposals, and many of the policies found in the proposed and this final rule are a direct result of these discussions and negotiations with the States. To the extent consistent with the objectives of the statute, to obtain substantial health care coverage for uninsured low-income children in an effective and efficient manner, we have endeavored to preserve State options in implementing their programs.

We developed these final regulations with the goal of providing a balanced view of both Medicaid expansions and separate child health programs. We made careful determinations as to whether each subpart should be applicable to separate child health programs *and* Medicaid expansions, or only to separate programs. In doing this, we have attempted to maximize flexibility and avoid the need for duplication of effort, while at the same time recognizing the basic differences between the two approaches.

We believe our considerations, and the consultative process we followed during the State plan review process, fully comported with the requirements of Executive Order 13132, and the final regulations contain the framework necessary for States to achieve the statutory requirements and objectives set forth by Congress.

Comment: Several commenters were concerned that the proposed regulations would narrow available State options, with particular mention of barriers to private sector models, and impose additional burdensome requirements on States. Some commenters were concerned that the proposed regulations would require administrative costs that would be a difficult financial burden for a small separate child health program.

Response: We recognize the commenters' concern and have tried to keep potential administrative burden in mind in developing these regulations. Some administrative investment, however, is necessary to ensure proper delivery of health care coverage to uninsured low-income children, and to provide enrollees with protections to ensure that such coverage is furnished in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

3. Table of Contents for Part 457

We set forth the new provisions for the State Children's Health Insurance Program in regulations at 42 CFR part 457, subchapter D. We note that the following table of contents is for all of part 457 and lists some subparts which have been reserved for provisions set forth in the May 24, 2000 final financial regulation (65 FR 33616).

Subchapter D—State Children's Health Insurance Program (SCHIP)

PART 457—ALLOTMENTS AND GRANTS TO STATES

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

Sec.

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Subpart G—Strategic Planning, Reporting, and Evaluation

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Subpart H—Substitution of Coverage

457.800 Basis, scope, and applicability.
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Subpart I—Program Integrity

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B. Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

1. Program Description (§ 457.1)

In proposed § 457.1, we set forth a description of the State Children's Health Insurance Program. Title XXI of the Social Security Act, enacted in 1997 by the BBA, authorizes Federal grants to States for provision of child health assistance to uninsured, low-income children. The program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures. We received no comments on this section and have retained the proposed language in this final rule.

2. Basis and Scope of Subchapter D (§ 457.2)

Proposed § 457.2 set forth the basis and scope of subchapter D. This subchapter implements title XXI of the Act, which authorizes Federal grants to States for the provision of child health assistance to uninsured, low-income children.

The regulations in subchapter D set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP) to enable States to provide health benefit coverage to targeted low-income children, as defined in § 457.310. We received no comments on this section and have retained the proposed language in this final rule.

3. Definitions and Use of Terms (§ 457.10)

This subpart includes the definitions relevant specifically to the State Children's Health Insurance Program under title XXI. In this subpart, we defined key terms that are specified in the statute or frequently used in this regulation. We note that those terms that are specific to certain subparts of this

regulation are defined at the opening of each subpart, however, all the terms are listed here. Because of the unique Federal-State relationship that is the basis for this program and because of our commitment to State flexibility, States have the discretion to define many terms.

We proposed the following definitions:

• *American Indian/Alaska Native (AI/AN)* means (1) a member of a Federally recognized Indian tribe, band, or group or a descendant in the first or second degree, of any such member; (2) an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act 43 U.S.C. 1601 *et seq;* (3) a person who is considered by the Secretary of the Interior to be an Indian for any purpose; (4) a person who is determined to be an Indian under regulations promulgated by the Secretary.

• *Child* means an individual under the age of 19.

• *Child health assistance* has the meaning assigned in § 457.402.

• *State Children's Health Insurance Program (SCHIP)* means a program established and administered by a State, but jointly funded with the Federal government to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination of both.

• *Combination program* means a program under which a State provides child health assistance through both a Medicaid expansion program and a separate child health program.

• *Contractor* has the meaning assigned in § 457.902.

• *Cost-effective* has the meaning assigned in § 457.1015.

• *Creditable health coverage* has the meaning given the term ''creditable coverage'' at 45 CFR 146.113. Under this definition, the term means the coverage of an individual under any of the following:

—A group health plan (as defined in 45 CFR 144.103).
—Health insurance coverage (as defined in 45 CFR 144.103).
—Part A or part B of title XVIII of the Act (Medicare).
—Title XIX of the Act, other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines).
—Chapter 55 of title 10, United States Code (medical and dental care for members and certain former members of the uniformed services, and for their dependents).
—A medical care program of the Indian Health Service or of a tribal organization.
—A State health benefits risk pool (as defined in 45 CFR 146.113).
—A health plan offered under chapter 89 of title 5, United States Code (Federal Employees Health Benefits Program).
—A public health plan. (For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivisions of a State that provides health insurance coverage to individuals who are enrolled in the plan.)
—A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

The term ''creditable health coverage'' does not include coverage consisting solely of coverage of excepted benefits including limited excepted benefits and non-coordinated benefits. (See 45 CFR 146.145)

• *Emergency medical condition* has the meaning assigned at § 457.402.

• *Emergency* services has the meaning assigned in § 457.402.

• *Employment with a public agency* has the meaning assigned in § 457.301.

• *Family income* means income as determined by the State for a family as defined by the State.

• *Federal fiscal year* starts on the first day of October each year and ends on the last day of September.

• *Fee-for-service entity* has the meaning assigned in § 457.902.

• *Grievance* has the meaning assigned in § 457.902.

• *Group health insurance coverage* means health insurance coverage offered in connection with a group health plan as defined at 45 CFR 144.103.

• *Group health plan* means an employee welfare benefit plan, to the extent that the plan provides medical care as defined in section 2791(a)(2) of the PHS Act (including items and services paid for as medical care) to employees or their dependents directly (as defined under the terms of the plan), or through insurance, reimbursement, or otherwise, as defined at 45 CFR 144.103.

• *Health benefits coverage* has the meaning assigned in § 457.402.

• *Health maintenance organization (HMO) plan* has the meaning assigned in § 457.420.

• *Joint application* has the meaning assigned in § 457.301.

• *Legal obligation* has the meaning assigned in § 457.560.

• *Low-income child* means a child whose family income is at or below 200 percent of the poverty line for the size family involved.

• *Managed care entity (MCE)* has the meaning assigned in § 457.902.

• *Medicaid applicable income level* means, with respect to a child, the effective income level (expressed as a percentage of the poverty line) that has been specified under the State plan under title XIX (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2)), as of March 31, 1997, for the child to be eligible for medical assistance under either section 1902(l)(2) or 1905(n)(2) of the Act.

• *Medicaid expansion program* means a program where a State receives Federal funding at the enhanced matching rate available for expanding eligibility to targeted low-income children.

• *Post-stabilization services* has the meaning assigned in § 457.402.

• *Poverty line/Federal poverty level* means the poverty guidelines updated annually in the **Federal Register** by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

• *Preexisting condition exclusion* has the meaning assigned at 45 CFR 144.103, which provides that the term means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

• *Premium assistance for employer-sponsored group health plans* means State payment of part or all of premiums for group health plan or group health insurance coverage of an eligible child or children.

• *Public agency* has the meaning assigned in § 457.301.

• *Separate child health program* means a program under which a State receives Federal funding from its title XXI allotment under an approved plan that obtains child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act.

• *State* means all States, the District of Columbia, Puerto Rico, the U.S.

Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

• *State health benefits plan* has the meaning assigned in § 457.301.

• *State plan* means the approved or pending title XXI State child health plan.

• *State program integrity unit* has the meaning assigned in § 457.902.

• *Targeted low-income child* has the meaning assigned in § 457.310.

• *Uncovered child* means a child who does not have creditable health coverage.

• *Well-baby and well-child care services* means regular or preventive diagnostic and treatment services necessary to ensure the health of babies and children as defined by the State. For purposes of cost sharing, the term has the meaning assigned at § 457.520.

We note that comments concerning definitions that are specific to certain subparts are discussed at the opening of those subparts. We received the following comments on the terms defined in this section:

Comment: We received a comment suggesting that we use the terms ''SCHIP'', ''Medicaid expansion program'' and ''separate child health program'' consistently throughout the regulation. The commenter noted that we repeatedly use the term ''SCHIP'' when it appears the term ''separate child health program'' is meant.

Response: We agree with the commenter and have revised the rule for clarity and consistency. Throughout this regulation, we use the terms ''Medicaid expansion program'' and ''separate child health program'' to refer to the different types of programs that States may establish under title XXI. These terms are defined at § 457.10. We use the term ''SCHIP'', also defined at § 457.10, to refer to the State's title XXI program regardless of whether it is a Medicaid expansion program or a separate child health program.

Also for purposes of clarity and consistency, we have added definitions of the terms ''applicant'', ''enrollee'', ''health care services'', and ''uninsured or uncovered child'' to the definitions section of the final rule. We felt that it was important to make clear both the distinctions and the similarities between these two groups of children for purposes of SCHIP (either individually or through action by family or other interested parties).

''Applicant'' means a child who has filed an application (or who has had an application filed on his/her behalf) for health benefits coverage through SCHIP. A child is an applicant until the child receives coverage through SCHIP. An ''enrollee'' is a child who receives health benefits coverage through SCHIP. ''Health care services'' means any of the services, devices, supplies, therapies, or other items listed in § 457.402(a). ''Uncovered child or uninsured child'' means a child who does not have creditable health coverage.

We have added a few definitions related to presumptive eligibility under Subpart C, including ''qualified entity'', ''presumptive income standard'' and ''period of presumptive eligibility''. The Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106–554) expanded the list of entities specifically eligible to make presumptive eligibility determinations and extended the provision related to presumptive eligibility for children under Medicaid to separate child health programs.

Finally, we have added the definition of ''health services initiatives'' to the overall definitions section because it is used throughout the regulation. This term was previously discussed only in Subpart J, in relation to the waiver authority to provide services through community-based delivery systems.

Comment: One commenter indicated that the definition of AI/AN should include a reference to the standards used by the Secretary to define an AI/AN. The commenter agreed with our use of section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c) to define AI/AN. The commenter believes our proposed definition will assist States in meeting requirements regarding the AI/AN population.

Another commenter indicated that our use of the definition of AI/AN set forth in the Indian Health Care Improvement Act is appropriate for purposes of the premium and cost sharing exclusion. However, the commenter notes that the proposed definition of AI/AN set forth at § 457.10 is narrowed by the cost-sharing provisions at § 457.535, which specify that only American Indians and Alaska Natives who are members of a Federally recognized tribe are excluded from cost-sharing charges. The commenter believes that the definition of AI/AN at § 457.535 is more restrictive than that set forth in the Indian Health Care Improvement Act and has no basis in title XXI. The commenter believes that the definition at § 457.535 is also inconsistent with the proposed consultation provisions of § 457.125(a), which expressly requests that States consult with ''Federally recognized tribes and other Indian tribes and organizations in the State * * *'' The commenter asserted that there is little point in consulting with non-Federally recognized tribes about enrollment in SCHIP if the children of those tribes are not excluded from premiums and cost sharing.

Response: We have modified the definition of AI/AN, after discussion with IHS, to make the definition as consistent as possible with both the Indian Health Care Improvement Act (IHCIA) and the Indian Self Determination Act. The definition no longer includes descendants, in the first or second degree, of members of federally recognized tribes, and we have removed the reference in paragraph (4) to regulations to be promulgated by the Secretary. We believe that this definition is substantially equivalent to, and no more restrictive than, the definition in the IHCIA, but is consistent with the flexibility available under the Indian Self Determination Act. We have used this definition because it gives full weight to federally recognized government-to-government relationship between the federal government and tribal governments. We do not intend, however, to restrict the States' ability to engage in a wider scope of consultation in developing their programs.

Comment: One commenter indicated that the definition of ''child'' is inconsistent with their State's statute which considers children up to age 19 for child support purposes. Another commenter supports HCFA's definition of family income as it gives States the flexibility to define income and family.

Response: The definition of ''child'' was taken from section 2110(c) of the Act. With regard to the definition of family income, we appreciate the support and want to give States as much flexibility as possible when defining this aspect of their SCHIP programs.

Comment: We received a comment on the definition of premium assistance for employer-sponsored group health plans. The commenter states that according to the definition of this term at § 457.10, a State can pay all or part of the premium. The commenter notes that this definition appears to conflict with proposed § 457.810(b)(2)(i) and (ii) which require that an employer contribute 60 percent of the cost of the premium, or a lower amount if the State can show that the average contribution in the State is lower than 60 percent, as a protection against substitution of coverage.

Response: The commenter is correct. In order for the purchase of employer-sponsored coverage to be cost-effective in accordance with § 457.810(b)(2), it was our intent to say that the State can pay for all or part of the enrollee's share of the premium for group health plan coverage of an eligible child or children. It is unlikely that a State's payment of

all of the premium would meet the cost-effectiveness test. Accordingly, we have revised the definition of premium assistance for employer-sponsored group health plans to indicate that a State can pay for all or part of the enrollee's share of the premium.

It should also be noted that, in this final rule we have made some significant changes in the list of terms defined, in order to clarify terminology for health benefits coverage provided through a group health plan or group health coverage. We defined the term ''premium assistance for employer-sponsored group health plans.'' We also used the term ''employer-sponsored group health plan'' and ''employer-sponsored group health plan coverage'' throughout the proposed rule.

In hopes of simplifying discussions of our policy, we have elected to create a new term that is intended to be inclusive of all types of group health coverage. We no longer use the term ''employer-sponsored'' prior to references to group health plan or group health insurance coverage in this final rule. We believe that the use of the term ''employer-sponsored insurance'' or ''employer-sponsored group health plan'' could unintentionally narrow the scope of permitted premium assistance programs and wanted to avoid that result. Under HIPAA, the term ''group health plan'' has a very specific legal meaning and refers to a broad array of coverage arrangements; it does not solely refer to health plans offered by a single employer. Therefore, we did not want to cause confusion around the possible scope of programs permitted under Title XXI by using the term ''employer-sponsored'' in connection with provisions relating to premium assistance programs and rather, refer to all of these types of programs accordingly.

Comment: One commenter suggested that HCFA include in the final rule the definition of ''health services initiatives'' set forth in the August 6, 1998 letter to State Health Officials. In the letter, the term is defined as ''activities that protect the public health, protect the health of individuals or improve or promote a State's capacity to deliver public health services and/or strengthens resources needed to meet public health goals.''

Response: We agree with the commenter. We have added the definition of ''health services initiatives'' as set forth in the August 6, 1998 letter.

Comment: Commenters asserted that the definition of well-baby and well-child care for purposes of cost sharing (set forth at § 457.520) be used in three other sections of the regulation: Definitions and use of terms § 457.10; Child health assistance and other definitions § 457.402; and Health benefits coverage options § 457.410(b)(2). One commenter urged that our recognition in § 457.520 that preventive oral health care is part of well-baby and well-child care be extended to the definition of this term at §§ 457.10, 457.402, 457.410(b)(2). The commenter believes that the definition of well-baby and well-child care which includes preventive oral health care should not be treated simply as a category of services left to State discretion for definitional purposes. The commenter noted that the Medicaid program provides for a comprehensive set of services and screenings for oral health care services through EPSDT services. The commenter believes that a clearly defined set of well-baby and well-child care benefits is essential to ensuring a baseline of care in separate child health programs.

Response: EPSDT services are required to be provided to eligible Medicaid beneficiaries under the age of 21 and are defined at section 1905(r) of the Act. Title XXI does not contain the same type of definition for well-baby and well-child care provided under a separate child health program. Therefore, States have the flexibility to design health benefits packages that best fit their needs and resources. In addition, for States that have elected benchmark plans as their health benefits option, these plans may already include standards for furnishing well-baby and well-child care; and it would be inconsistent with the flexibility provided by the statute in this area, as well as cause confusion among plans and providers if we implemented another definition.

Although most separate child health plans do include some type of dental coverage, it is by no means common. Therefore, it is not appropriate to require these services as part of well-baby well-child care. If dental coverage is provided, however, it should be included as part of well-baby well-child care for purposes of cost sharing. Specifically, dental care can be viewed as the oral health equivalent of immunizations in that it can prevent most cavities and subsequent tooth loss, both of which are highly correlated to poverty and lack of access to dental care. Second, we found that the prevailing practice among State employee plans and large HMOs is to pay 100 percent for any routine preventive and diagnostic dental benefits offered for children. Therefore, consistent with section 2103(e)(2) of the Act ''no cost-sharing on benefits for preventive services'' cost sharing may not be applied to these services, if a State chooses to offer them under the State plan.

Comment: Commenters suggested including the word ''adolescent'' in the definition of well-baby and well-child care services. The commenters believe that we should focus on the unique health needs of adolescents, which make up approximately 39 percent of SCHIP eligible youth because their health needs differ from those of younger children. The commenters also urged HCFA to list specifically in the regulation medical sources that have guidelines for regular or preventive diagnostic and treatment services for infants, children and adolescents. These sources should include the American Academy of Pediatrics' ''Guidelines for Health Supervision of Infants, Children and Adolescents,'' the American Medical Association's ''Guidelines for Adolescent Preventive Services,'' and the American College of Obstetricians and Gynecologists' ''Primary and Preventive Health Care for Female Adolescents.''

Response: We have not adopted this suggestion. The definition of child for purposes of SCHIP at § 457.10 and section 2110(c)(1) of the Act indicates that a ''child'' is an ''individual under the age of 19.'' Adolescents under age 19 are clearly included in this age group and therefore we have not included this term in referring to well-baby and well-child care. We encourage States to adopt one of the guidelines mentioned by the commenter, but we have not required adherence to a particular definition.

The commenters urged HCFA to list specifically in the regulation medical sources that have guidelines for regular or preventive diagnostic and treatment services for infants, children and adolescents. The examples of medical sources that are listed in the preamble are meant to serve as recommendations not requirements. The American Medical Association's ''Guidelines for Adolescent Preventive Services,'' is an acceptable medical standard of practice for adolescents and States may use this standard if they choose.

Comment: We received numerous comments on proposed § 457.402(b) and (c), which set forth the definitions of emergency medical condition and emergency services, respectively. Many commenters supported the use of the prudent layperson standard in defining emergency services. Several commenters encouraged HCFA to retain this language because some State Medicaid programs and managed care organizations are not in compliance

with the prudent layperson standard and have denied payment for emergency services because prior authorization was absent. The commenters recommended that HCFA closely monitor the States' programs and managed care organizations on this issue.

Response: We note the support for this provision. With respect to the definition of emergency services under a separate child health plan, States will need to review their contracts with managed care organizations and may need to revise their contracts in order to comply with this requirement. HCFA will monitor States for compliance with this requirement as described in § 457.40 of the final regulation.

Comment: One commenter stated that the required emergency care provisions may disqualify many employer plans. The commenter agreed that such policies can enhance access to emergency care. However, the commenter noted that States using premium assistance programs to subsidize employer-sponsored coverage lack control over emergency coverage. Unlike health plans with direct contracts to provide Medicaid or SCHIP services, requirements for employer-sponsored plans are set by State legislative mandate or dictated by the insurance market. If employer-sponsored plans do not adopt the prudent layperson standard or abandon pre-authorization for emergency care, their coverage may not qualify for SCHIP premium assistance, despite other elements that facilitate emergency care. The emergency care provisions could therefore pose a major barrier to using premium assistance programs for SCHIP purposes.

The commenter recommended that HCFA recognize that the emergency care requirements of the proposed regulations may exclude many valuable employer plans from SCHIP premium assistance programs. To facilitate the use of premium assistance and to reflect the flexibility provided by title XXI, the commenter suggests that HCFA should consider State approaches to ensuring access to emergency care on a case-by-case basis.

Response: We appreciate the recognition that the prudent layperson standard enhances access to emergency care. While we understand the commenter's concerns about the difficulty posed by these requirements if States seek to provide premium assistance for available group health plan coverage, we cannot permit States to deny emergency care to children covered through group health plans. While we encourage States to provide premium assistance for group health plan coverage, it is important that all SCHIP enrollees receive necessary emergency care. States will need to carefully review group health plans to determine whether the required emergency services provisions required by this regulation are in place. If they are not, the State must disqualify those plans from participation in the program or ensure that these requirements are met by providing coverage for emergency services through a wrap-around coverage package to supplement the group health plan coverage.

Comment: One commenter noted that the definition of emergency services should include the availability of necessary resources to evaluate and treat illness and injury.

Response: We have revised the definition of emergency services to clarify the scope of such services. Because the terms ''emergency medical condition'' and ''emergency services'' are used throughout this final regulation, we have moved the definitions for these terms to § 457.10. Section 457.10 defines ''emergency services,'' in part, as services that are ''needed to evaluate or stabilize an emergency medical condition.'' ''Emergency medical condition'' is defined as a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child; serious impairment of bodily function; or serious dysfunction of any bodily organ or part. Section 457.495 requires that States describe in their State plan the methods they use to assure the quality and appropriateness of care and access to services covered under the plan. Specifically, States must assure access to emergency services. We are not including requirements for State monitoring of such services in the definition because we address such monitoring separately at § 457.495. Compliance with that section includes an assurance that enrollees have access to required emergency services.

Comment: One commenter referenced comments on the proposed Medicaid managed care rules that concerned consistency with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. The commenter suggested HCFA should coordinate its efforts to enforce relevant requirements for coverage of emergency services with EMTALA enforcement, and should work with OIG, State Medicaid agencies, health plans, and children's health programs to protect Medicare, Medicaid, and SCHIP enrollees.

Response: The comments submitted on the Medicaid managed care regulation are beyond the scope of the proposed rule. Responses to comments received on the Medicaid managed care proposed rule will be addressed in the final publication of that regulation.

With respect to the issue of consistent Federal rules, we are mindful of other definitions of emergency services and have attempted to reconcile our approach with other approaches to the extent permitted by the statute. As for coordination of enforcement efforts, HCFA will monitor the operation of State plans as described in § 457.40 of this final regulation and work with States and other Federal agencies to the extent possible in enforcing the requirements relating to coverage of emergency services.

Comment: One commenter mentioned the need to provide for appropriate payment to hospitals for services provided within the scope of the hospital's obligations under EMTALA. Hospitals feel that if the government requires certain medical screening and other stabilizing treatment, the government should also address how hospitals will be paid for these services. They also noted that obtaining payment for services covered under the prudent layperson standard will help to address the financial burden borne by hospitals.

Response: We refer the commenter to § 457.940 for information on payment rates under separate child health plans. We encourage States to ensure that provider payments are adequate to promote an adequate level of provider access and provider participation and the appropriate provision of services.

Comment: One commenter noted that freestanding urgent care facilities must have the capability to identify children with emergency conditions, stabilize them, and provide timely access to further necessary care. The commenter also stated that urgent care facilities must have appropriate pediatric equipment and staff trained and experienced to provide critical support until patients are transferred for definitive care. In addition, the commenter noted that it is necessary for urgent care facilities to have prearranged access to comprehensive emergency services through transfer and transport agreements to which both facilities adhere. Available and appropriate modes of transport should be identified in advance.

The commenter also noted that after-hours urgent care clinics used as a resource for pediatric urgent care, should solicit help from the pediatric

professional community. Moreover, in this commenter's view, pediatricians who are prepared to assist in the stabilization and management of critically ill and injured children should be accessible. Pediatricians responsible for managing the health care of children may occasionally need to use the resource of urgent care facilities after hours. When such clinics are recommended to patients, pediatricians should be certain that the urgent care center is prepared to stabilize and manage critically ill and injured children.

Response: As noted earlier, under § 457.495 of this final regulation, States must assure appropriateness of care and access to emergency services. A State has flexibility to determine the providers who furnish services, including emergency services. However, a State using free-standing or urgent care facilities as providers under its SCHIP plan for the delivery of emergency services, must meet the requirements of § 457.495 in doing so.

As far as the suggestion that available and appropriate modes of transport be identified in advance, we encourage States and urgent care providers to have arrangements to ensure that transportation is available to appropriate facilities; however the terms of such arrangements are left to States' discretion.

Comment: One commenter is pleased with the guaranteed access to emergency services without prior authorization; however, the commenter was concerned about what happens in a State that provides for no mental health coverage in its State plan.

Response: Under a separate child health program, States are given flexibility, within the confines of the health benefits coverage options outlined in § 457.410, to design their benefit packages. There is no requirement for a State to provide mental health services under its State plan unless the health benefits coverage option selected by the State includes those services. However, we encourage States to provide coverage for mental health services. In addition, we note that emergency mental health services that meet the prudent layperson definition of ''emergency medical condition'' must be available regardless of whether mental health services are covered under the separate child health program.

Comment: Three commenters indicated that children who were covered by section 1115 demonstration projects with a limited benefit package should not be considered to have been recipients of Medicaid. The commenters urged HCFA to provide clarification on the treatment of children eligible for Medicaid under a section 1115 demonstration project that limited eligibility or provided a limited range of services and the availability of enhanced matching for such children.

Response: We agree with the general principle expressed by the commenters that it would not further the purpose of title XXI to exclude from children who were eligible only under a section 1115 demonstration project that was significantly limited in scope and, therefore, was not generally comparable with traditional Medicaid coverage.

In regard to the definition of ''targeted low income child'' at section 2110(b)(1)(C) of the Act, children are excluded from coverage in a separate child health program only when they are found eligible for Medicaid. These comments are relevant, however, the interpretation of the general condition set forth at section 2105(d)(1) of the Act which was implemented by the regulatory provision at 42 CFR 457.622(b)(5), contained in the financial rule published May 24, 2000 (65 FR 33616). That provision merely codified section 2105(d)(1) into regulations without interpretation. In addition, the factors discussed by the commenters affect how we look at ''Medicaid applicable income level'' which is part of the financial need standard that a targeted low-income child must meet.

We have added an additional paragraph to § 457.310 that clarifies that policies of the State's title XIX plan do not include statewide section 1115 demonstration projects that covered an expanded group of eligible children but that either (i) did not provide inpatient hospital coverage, or (ii) did not impose a general time limit on coverage but did limit eligibility by both allowing only children who were previously enrolled in Medicaid to qualify and imposing premiums as a condition of participation in the demonstration.

We have excluded these types of demonstrations because they were particularly narrow in scope and not of the type intended to be encompassed by the reference to ''Medicaid applicable income level'' in section 2110(b)(4) of the Act. This provision ensures that separate child health programs serve low-income children whose income exceeds preexisting Medicaid income levels. However, we do not believe the provision was intended to preclude States from claiming enhanced matching funds for expanded coverage to children whose income is below the demonstration project eligibility thresholds in place as of March 31,1997, if those programs did not offer comprehensive coverage or limited eligibility to individuals who were previously enrolled in Medicaid. Our experience with SCHIP and our increased understanding of how this provision is affecting States' ability to expand coverage have led us to agree with the commenters that an overly broad interpretation of the provision is contrary to the primary purpose of the statute. We have clarified this provision in the final rule accordingly. As a result, children previously eligible for these types of demonstration projects may be included in a separate child health program as a ''targeted low-income child.''

4. Basis, Scope, and Applicability of Subpart A (§ 457.30).

As proposed, this subpart interprets sections 2101(a) and (b), and 2102(a), and 2106, and 2107(c), (d) and (e) of title XXI of the Social Security Act and sets forth the related State plan requirements for a SCHIP program. It includes the requirements related to administration of the State program, the general requirement for a State plan and the process for Federal review of a State plan or plan amendment. This subpart applies to all States that seek to provide child health assistance through SCHIP.

We received no comments on this section and have therefore retained the regulation text language as proposed, except for technical changes.

5. State Program Administration (§ 457.40)

Consistent with section 2106(d)(1) of the Act, at § 457.40(a) we proposed that it is the State's responsibility to implement and conduct its program in accordance with the approved State plan and plan amendments, the requirements of title XXI and title XIX (as appropriate), and the regulations in chapter IV.

To ensure that the State is operating its program accordingly, we indicated that HCFA would review the operation of the program through on-site review or monitoring of State programs. At § 457.40(a), we also proposed that HCFA would monitor the operation of the approved State plan and plan amendments to ensure compliance with title XXI, title XIX (as appropriate) and the regulations in chapter IV. In the preamble to the proposed rule we discussed in detail the general goals for the monitoring provisions as well as expected outcomes of monitoring. We noted that the review process and the implications of noncompliance are specifically addressed in § 457.200, which was set forth in the May 24, 2000

final financial regulation, HCFA–2114–F. (65 FR 33616)

To ensure involvement in and commitment to the program at the highest level of State government, we proposed in § 457.40(b) to require that the State plan and plan amendments be signed by the Governor or by an individual who has been delegated such authority by the Governor. This individual could be the Secretary of Health, the SCHIP Administrator, the Medicaid Director or any other individual who has been delegated authority by the Governor to submit the State plan or plan amendment. In order to facilitate communication between the appropriate State and HCFA staff, we proposed in § 457.40(c) to require that the State plan or plan amendment identify the State officials who are responsible for program administration and financial oversight.

We noted in the preamble that when the passage of State enabling legislation is required to implement a State plan, a State can submit its State plan application before the passage of the legislation. States must indicate in their application if such legislation is necessary and when it will be in place. At § 457.40(d), we proposed that the State plan must include an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by HCFA.

Comment: One commenter recommended that § 457.40(a) be amended to clarify that States must operate State plans and plan amendments not only in accordance with titles XIX and XXI, but also in accordance with Federal civil rights laws, including title VI of the Civil Rights Act of 1964 and the Americans With Disabilities Act. Accordingly, the commenter recommended that HCFA also monitor the operation of the State plans and plan amendments for compliance with these laws.

Response: It is true that States must operate State plans and plan amendments in accordance with Federal civil rights laws, and we require in § 457.130 that a State provide an assurance in its State plan that it will comply with all applicable civil rights requirements. In addition, § 457.40(a) requires that States implement their programs in accordance with the regulations of this chapter, which include § 457.130. Therefore, we do not believe that it is necessary to amend § 457.40(a) to reference civil rights provisions. Moreover, while HCFA will monitor compliance with § 457.130, the Office for Civil Rights is the primary authority within the Department for monitoring programs and enforcing federal civil rights laws.

Comment: A few commenters suggested that States should be able to designate the program officials by title only, rather than by name, so that the State plan does not need to be amended when there is a staffing change. Another commenter suggested that a Governor or person designated by the Governor inform HCFA in writing of the names of the persons who are responsible for program administration and financial oversight. Another commenter requested that HCFA add a requirement that States identify in the State plan or in a subsequent State plan amendment the State officials who are responsible for providing data on children's enrollment in SCHIP and Medicaid.

Response: We agree with the commenters that it is unnecessary to require State plan amendments when there is a staffing change. Our goal of facilitating communication between the appropriate State staff and HCFA staff would be accomplished by the identification of program officials by position title. As proposed, the regulation text did not indicate that this practice would suffice, and the preamble had indicated that the names of the officials would be required. Therefore, we are revising § 457.40(c) to require that the State must identify, in the State plan or State plan amendment, the position title of the State officials who are responsible for program administration and financial oversight. While we agree with the importance of obtaining enrollment data on a timely basis, we do not believe that the State plan or plan amendments must include a list of program officials who are responsible for specific topics addressed in the State plan, including the official responsible for providing enrollment data. An interested party may contact the individual identified as the official responsible for program administration for specific information on the State program.

Comment: One commenter supported the provision of the proposed rule that prohibits the implementation of a State plan amendment until the amendment had been authorized through enabling legislation by the State legislature if such authorization is required. In this commenter's opinion, ''this represents an important recognition of the ongoing role of the State legislature with the design and operation of SCHIP.''

Response: We appreciate the support of the commenter.

Comment: A few commenters expressed their support for the proposal stated in the preamble to conduct formal State reviews after the first anniversary of each State plan to ensure compliance with the requirements of titles XXI and XIX. More specifically, one commenter commended HCFA for including HRSA officials in the State review.

Response: We appreciate the support of the commenters.

Comment: One commenter found it disappointing that the focus of monitoring of State programs, as set out in the preamble, appeared to be punitive in nature. In the view of this commenter, it appeared that the Department was anticipating the failure of the States to comply and that it therefore must be ready to take corrective and enforcement actions. The commenter suggested that, at the very least, ''identifying the need for corrective action, enforcement and improvement within the State title XXI programs'' should be the last of the four listed expected outcomes of the monitoring.

Response: We did not intend to be punitive, nor do we anticipate the failure of the States to comply with statutory or regulatory requirements or the specifications of the approved State plan. During the monitoring visits that have taken place thus far, the Department has focused on identifying best practices and needs for technical assistance rather than on compliance. In keeping with the commenters' views, we have rearranged the list of expected outcomes of monitoring as follows: (1) Recognizing and sharing best practices that may lead to increased enrollment; (2) identifying States' needs for technical assistance; (3) informing HCFA as we prepare for the Secretary's report to Congress; and (4) identifying the need, if any, for corrective action, enforcement and improvement within State title XXI programs.

Comment: One commenter recognized that ongoing review of State programs is an evolving process, but suggested that HCFA identify either in this regulation or in a separate policy document ''the core set of key policy areas'' that it intends to monitor and to establish a protocol for doing so. The commenter specifically recommended adopting as key policy areas the methods to address the needs of racial and ethnic minority children and the needs of children with disabilities.

Response: The HCFA Central Office and Regional Offices develop procedural guidelines to use in the ongoing operation of the monitoring visits and review process. In the flexible Federal review process that we have established, we will monitor to ensure consistent implementation of the core

set of key policy areas specifically described in the title XXI statute. These areas include enrollment and retention procedures; outreach; coordination with other programs; quality, appropriateness and access to care; and other areas related to compliance with the statute, regulations and approved State plan. Because the review process may change over time and may vary from region to region, depending upon specific State needs and circumstances, we do not believe it is appropriate to further specify these procedures in regulation. We agree with the commenter's concern regarding the needs of racial and ethnic minority children, as well as children with special needs, and we plan to incorporate these issues into our monitoring as appropriate. Furthermore, in recognition of the importance of assessing how SCHIP is addressing the needs of racial and ethnic minority children, we have added reporting requirements to subpart G, at § 457.740(a)(2)(ii) for data on race, ethnicity and primary language as well as gender. We hope that these data, together with ongoing monitoring, will enable States, HCFA, and other interested parties to assess these important policy areas.

Comment: Many commenters indicated that it is essential for HCFA to add a requirement that State and local community based organizations and ''stakeholders'' be involved in HCFA's annual reviews of State SCHIP operations. One commenter explained that it is a practical reality that State officials are at times constrained in their ability to identify problems in their programs candidly; therefore, the inclusion of a diverse group of stakeholders would considerably strengthen HCFA's understanding of State operations and would improve accountability of State programs to their constituents. One commenter recommended including language to recognize the critical role that consumers, advocates, providers, and others play in the design, implementation, and monitoring of SCHIP programs. One of these commenters suggested a public hearing as part of the review. Several commenters expressed a desire that, in providing public input, HCFA provide these organizations and stakeholders with draft and final reports generated through the review process.

Response: We recognize the importance of public involvement in the monitoring process. As part of our ongoing monitoring of programs, including site visits, we have met with advocates, providers and other interested parties, and we have incorporated such contacts into our monitoring protocol. In many cases, as part of the SCHIP site visits, the Regional Office staff have met with advocates and providers to gain additional input on the State's programs. We plan to regularize such conduct, but do not plan to hold public hearings in the course of monitoring of State programs. Moreover, HCFA encourages stakeholders to contact their Regional Office at any time to inform them of issues, suggestions and concerns. The statute specifically requires public input in the development and implementation of SCHIP. Section 2107(c) of the Act, which requires public involvement, and the requirement at § 457.120, reflect the recognition of the importance of involvement of interested parties in the initial design and ongoing implementation of SCHIP. While we will value public input in the monitoring process, to avoid confusion that may be caused by inaccuracies in a draft monitoring report, we do not plan to release draft reports. We will provide final reports to interested parties upon request and encourage such parties to inform us of their comments on these reports.

Comment: One commenter encouraged HCFA to consult with key State level agencies, including Title V Maternal and Child Health and Children with Special Health Care Needs (MCH/CSHCN) programs, in conducting the reviews. In the views of this group, agencies that run State title V MCH/CSHCN programs are involved in SCHIP outreach and enrollment and are vital resources for understanding how SCHIP is working and, particularly, how it fits with other child and family services. One State specifically stated that the Child Support Enforcement (CSE) program should be included in the monitoring because CSE needs to be made aware of children in the child support enforcement caseload that are covered by this type of insurance.

Response: We will monitor for compliance with all regulatory requirements, including the requirement that States coordinate with other sources of health benefits coverage. This may include consulting with other State agencies or programs in conducting reviews as appropriate based on the unique circumstances in the State. We also encourage States to include these partners in the review process. We agree that the Child Support Enforcement agency is an important partner in coordination efforts in the SCHIP program, and issued guidance to this effect in a Fact Sheet on SCHIP and CSE released in January 1999. While we will not require their participation in the monitoring process, our Regional Offices have and will continue to work with State SCHIP agencies to help them identify key partners, including CSE agencies. Further discussion of our requirements for coordination with other programs is found in our responses to comments on § 457.80.

Comment: One commenter recommended that State legislators be included in HCFA site visits that occur as part of the review process.

Response: Because the legislative relationship with SCHIP is different in each State, States may have a widely varying degree of State legislator involvement in the ongoing implementation of their SCHIP programs. State legislators have a key role in the development and oversight of SCHIP programs; however, we do not believe it is appropriate for HCFA to require the inclusion of State legislators in every site visit, as that would intrude into the relationship between State executive and legislative branches. We are, however, willing and interested in meeting with State legislators who have an interest in SCHIP and appreciate their involvement and the special role they play in making SCHIP a success in their home State.

6. State Plan (§ 457.50)

We proposed that the State plan is a comprehensive written statement submitted by the State to HCFA for approval. The State plan describes the purpose, nature, and scope of its SCHIP and gives an assurance that the program will be administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program. We stated in the preamble that an approved State plan is comprised of the initial plan submission, responses to requests for additional information, any other written correspondence from the State and subsequent approved State plan amendments.

Comment: Several commenters strongly recommended consolidating the State plan into one up-to-date document rather than allowing the ''plan'' to be a conglomeration of the ''initial plan submission, responses to request for additional information and subsequent approved State plan amendments.'' Without such consolidation, the commenter indicated that the job of understanding the details of the program is extremely difficult for

policy makers, advocates, and researchers.

Response: We agree that, as some States receive approval for multiple State plan amendments, it will become more difficult to understand the details of the State programs. At this point, an approved State plan is comprised of the initial plan submission, responses to requests for additional information, any other written correspondence from the State related to provisions in the State plan or amendment and subsequent approved State plan amendments. However, in the future, we will request that all States submit consolidated State plans. At such time, we will issue guidance on the format and time frames for submission of a consolidated State plan.

Comment: A commenter asked that, in order to ensure that it will be possible to track States SCHIP policy choices over time, HCFA should commit to keep a copy of each States up-to-date, approved State plan in effect at the beginning of each fiscal year for future reference. Thus, the commenter observed, even if a State plan is subsequently amended, HCFA will have a record of the policies in place for any given State at the beginning of each fiscal year. By keeping an annual ''snapshot'' of States' SCHIP plans, the commenter noted that HCFA will make it possible for Federal, State, and local policy makers, as well as researchers, to evaluate the impact over time of States' SCHIP implementation choices.

Response: We will continue to keep a record of all State plans, including historic provisions with the effective date of each State plan amendment, so that we will have record of, and be able to make available to others, the policies that were in effect at any given time throughout the operation of a State's program.

Comment: One commenter stated that the plan should be ''easily accessible.'' One commenter suggested that the preamble language state that the approved State plan, including any attachments, will be made available to the public on the web.

Response: We will continue to make an effort, as resources permit, to make the approved State plan and any approved State plan amendments available to the public on the web site or through links to State sites. To facilitate the posting of this material, we encourage States to submit proposed plan amendments and responses to requests for additional information in an electronic format.

7. Amendments (§ 457.60)

Section 2106(b)(1) of the Act permits a State to amend its approved State plan in whole or in part at any time through the submittal of a plan amendment. We proposed in § 457.60(a) that the State plan must be amended whenever necessary to reflect changes in Federal law, regulations, policy interpretations or court decisions; changes in State law, organization, policy or operation of the program; or changes in the source of the State share of funding. In the preamble to the proposed rule, we discussed in detail our view that only changes that are substantial and noticeable would require amendments. Specifically, we stated that changes in program elements that would not ordinarily be required to be included in the State plan at all would not require an amendment. We proposed in § 457.60(b) that when the State plan amendment makes any modification to the approved budget, a State must include an amended budget that describes the State's planned expenditures for a three year period.

Comment: A few commenters suggested that HCFA provide SCHIP programs with ''preprints'' such as those provided in the Medicaid program to inform the State of changes in Federal law and regulations.

Response: We agree with commenters that providing preprints would assist States in complying with changes in Federal laws, regulations and policies. In Medicaid, a ''preprint'' is similar to the State plan template we have provided in SCHIP, where the State agrees to administer the Medicaid program in accordance with federal law and policy. The Medicaid State plan preprint sets forth the scope of the Medicaid program, including groups covered, services provided, and reimbursement rates for providers. In SCHIP, we have provided States with a State plan template, which also serves as the template for amendments to the State plan, and lays out in a series of questions and check boxes a guideline for States to follow in explaining the components of their program. We will be revising this template to reflect the provisions of this final regulation.

Comment: Many commenters asked that States be given a reasonable amount of time to implement new Federal requirements. One State specifically recommended that each State's contracting cycle time be used as the appropriate implementation time frame for new requirements. Another commenter urged the Department to take into consideration the many factors outside of Governors' control, such as contract cycles and legislative sessions, in determining when States must achieve final compliance.

Another commenter strongly urged that HCFA add a new subsection to § 457.60 that establishes a procedure by which States can submit State plan amendments that bring their State plans into compliance with the requirements of title XXI as set forth in the final version of the regulation. This commenter suggested that HCFA give States no more than six months after the issuance of the final regulations to submit State plan amendments that bring them into compliance.

Response: Most of the rules set forth in these final regulations are not new; in most cases, these rules reflect the pre-regulatory guidance issued since SCHIP was enacted into law. However, we note the commenters' concern that States need a reasonable amount of time to implement new Federal rules that have been promulgated in response to the comments received. We have considered that compliance with these final rules may require State legislation or changes to contracts. We will require that States come into conformity with new requirements within 90 days of publication of this rule, or if contract changes are necessary, the beginning of the next contract cycle. By contract cycle, we mean the earlier of the date of the end of the original period of the existing contract, or the date of any modification or extension of the contract (whether or not contemplated within the scope of the contract). If a new regulatory provision requires a new or amended description of procedures in the State plan, the State must implement the procedures within the above time frame, but the State plan amendment does not necessarily need to be submitted within the 90-day period as provided in § 457.65(a)(2). For example, if this final regulation were published on January 1, 2001, then States would have to comply with all new requirements by March 31, 2001 (unless the implementation of the new regulatory provision requires a contract change.) If a State needs to amend the State plan to include a new or revised description, then the State still must implement the new requirement by March 31, 2001, and must submit the State plan amendment by the end of that State fiscal year, or, if later, the end of the 90-day period.

Comment: A commenter requested that we require State plan amendments to describe the steps the State has taken to ensure that any organizations with which it contracts using title XXI funds are in full compliance. In some cases, the commenter noted, it is possible that a State will be unable to comply with

aspects of the final rule until it completes a contract cycle or convenes a legislative session. In such cases, the commenter recommended that a State could be given the opportunity to negotiate an alternative time frame with HCFA for implementation of selected aspects of the final rule.

Response: We do not agree with the suggestion that we require States to describe in their State plans how they have assured compliance of its contractors with title XXI. The State has the responsibility under section 2106(d)(1) of the Act for ensuring that the State, including its contractors, fulfills the obligations of title XXI. If we find through monitoring that services are being provided in a manner that is substantially noncompliant with applicable Federal law, regulations and the approved State plan, then we may take compliance actions in accordance with subpart B of part 457 (promulgated at 65 FR 33616, May 24, 2000).

Comment: One State indicated that modifications to its State plan to reflect changes in Federal law would be ''counterproductive'' because substantial changes to the ongoing program to come into compliance with new regulations could lead to coverage delays for some children. This same State also recommended that any new regulations or policy interpretations that would restrict or substantially alter a State's SCHIP should apply only prospectively, that States should not have to amend their approved State plans retroactively, and that ''agreements that were previously approved should not be changed unless HCFA could prove that a beneficiary would be substantially harmed in the absence of such a change.'' If HCFA requires States to make changes retroactively, this State recommended that HCFA should provide additional funds to help States finance the costs of the changes and that these funds should not be deducted from the States' title XXI allotments.

Response: We are requiring that States comply with this final rule on a prospective basis. States will not need to comply with new requirements retroactively. As previously set forth, this regulation will take effect 90 days after the publication date, although, if contract changes are necessary to comply with a particular requirement States will not be considered out of compliance if they do not comply with that requirement until the beginning of the next contract cycle, as described above. Pre-existing Federal requirements that have been incorporated into this regulation are already effective. States that are not complying with these pre-existing requirements could be subject to an enforcement action.

Comment: Several commenters asserted that proposed § 457.60(a)(2) requiring a State plan amendment to reflect ''[c]hanges in State law, organization, policy or operation of the program'' was too expansive and exceedingly burdensome. One commenter suggested that operational changes that do not affect eligibility or benefits not be treated as changes that require State plan amendments. Another commenter recommended that we require a State plan amendment only for a change that eliminates, restricts, or otherwise modifies eligibility, even if the change impacts only a small number of enrollees.

Some commenters recommended that the State plan amendments should be required for any changes in the following areas: (1) Eligibility, including crowd-out policies; (2) benefits, including type, scope, and duration; (3) cost sharing; (4) data reporting; (5) screen and enroll procedures under §§ 457.350 and 457.360; (6) procedures for rationing access to enrollment; (7) disenrollment for failure to pay cost sharing or for cause; and (8) substantial changes in outreach and enrollment policies.

Response: We agree that the proposed requirement set forth at proposed § 457.60(a)(2), (now § 457.60(b)), was administratively burdensome. Our intention was better reflected in the preamble to the proposed rule, although this, too (particularly our use of the phrase ''substantial and noticeable'') merited further clarification. We had specifically requested comments on this issue in the preamble to the proposed regulation.

In light of these comments, we have revised § 457.60 to be more precise about when amendments must be submitted. We have revised proposed § 457.60(a)(1), now § 457.60(a), to generally require a State to amend its State plan whenever necessary to reflect changes in Federal law, regulations, policy interpretation, or court decisions, that affect provisions in the approved State plan. This element of the final rule assures that a State keeps its State plan up-to-date; this is particularly important to assure ongoing public involvement in program implementation. We have revised proposed § 457.60(a)(2), now § 457.60(b), to require a State to amend its State plan whenever necessary to reflect changes in State law, organization, policy or operation of the program that affect key program elements. Thus, amendments are required when there are changes in eligibility, including but not limited to enrollment caps and disenrollment policies; procedures to prevent substitution of private coverage, including exemptions or exceptions to required periods of uninsurance; the type of health benefits coverage offered; addition or deletion of benefits offered under the plan; basic delivery system approach; cost sharing; screen and enroll procedures, and other Medicaid coordination procedures; and other comparable required program elements. We may issue guidance to further interpret ''other comparable required program elements'' as the program evolves and experience demonstrates that there are other changes that should require an amendment.

We do not agree that required State plan amendments should be limited only to those that eliminate or restrict eligibility or benefits. We also have not required a State plan amendment for changes in data reporting, as suggested by the commenters, because for approval of a State plan, a State is only required to provide an assurance that it will provide data as required by HCFA and that data may change over time. Finally, we have not required a State plan amendment for substantial changes in outreach strategies, as suggested by the commenters, because we believe that a State needs to have flexibility to adapt its outreach strategies as frequently as it finds necessary to best reach potentially eligible children without having to submit a State plan amendment in order to do so.

Comment: Several commenters praised HCFA for noting in the preamble its intent only to require an amendment for substantial and noticeable program changes and hoped this flexibility would be reflected in the final rule.

Several commenters noted that ''substantial and noticeable'' changes can be interpreted in a variety of ways, depending upon whom the change affects. One commenter noted that a change that affects the eligibility of 300 families across the State, 25 families in one community, or a particular group such as immigrant families, will be substantial and noticeable to the affected families, but likely to be inconsequential and unnoticed by the rest of the State or the community. Another commenter recommend that the ''substantial change'' language be added to the regulation text, as opposed to only being mentioned in the preamble, given that courts and other agencies cannot rely on language contained only in the preamble.

Response: We appreciate the commenters' support for our general

intent to require amendments only for significant and noticeable program changes. As discussed above, we agree that the discussion of this issue in the preamble to the proposed rule was not clear and did not provide sufficient guidance to States. Further, we agree that the policy should be included in the regulation text to ensure proper implementation. Therefore, we have revised § 457.60(a) (now § 457.60(b)) to clarify when a State plan amendment will be required, by identifying the categories of changes that, by their nature, have a significant effect. State plan amendments will be required for all program changes that fall into these categories.

Comment: One commenter believes that HCFA should not require either State plan amendments or public input for small program changes.

Response: As noted in previous responses, we have revised proposed § 457.60(a)(2), now § 457.60(b), to specify those changes that require a State plan amendment; the rules assure the plan will be revised to reflect significant program changes. We require States to provide assurances that it permits ongoing public involvement once the program has been implemented, and we require certification of public notice for State plan amendments relating to eligibility and benefit restrictions pursuant to § 2106(a)(3)(B) of the Act (see § 457.65(b)(1).) We are not, however, requiring that a State routinely certify that it has obtained public input prior to submitting a plan amendment to HCFA. We encourage States to obtain meaningful public input prior to submission of a State plan amendment and believe that public involvement prior to the implementation of a program change would constitute an important part of the ongoing public involvement. Further discussion of requirements for public involvement are found in response to comments on § 457.120.

Comment: One commenter suggested that proposed § 457.60(a)(3) (now § 457.60(c)) and § 457.65(d)(2) (the section containing more detail on State plan amendments regarding changes in certain sources of funding) be combined for organizational purposes. Another commenter recommended that HCFA delete the requirement that a State submit a State plan amendment when the source of the State share of the SCHIP funding changes because the source of State funding is ''irrelevant.'' Another commenter recommended that HCFA should consider another mechanism for ensuring that States do not use prohibited revenue sources such as impermissible provider taxes or donations. One commenter noted that this requirement will deter States from modifying their plans in order to better provide health services to children in need.

One commenter asserted that a certification by the State should be sufficient to assure that the State is not using impermissible taxes. Another commenter suggested that federal concerns would be better addressed by an effort to educate States as to the statutory limitations on such taxes.

Response: We agree that combining proposed § 457.60(a)(3) and § 457.65(d)(2) makes organizational sense because both relate to changes in the source of a State share of funding. Therefore, we have deleted proposed § 457.65(d)(2) and revised proposed § 457.60(a)(3), now § 457.60(c), to include the substance of § 457.65(d)(2). Section § 457.60(c) now requires a State to amend its State plan whenever necessary to reflect changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

However, we disagree with the commenter's recommendation to delete proposed § 457.60(a)(3), now § 457.60(c). The source of State funding is relevant because Section 2107(d) of the Act requires a State plan to include a description of the budget for the plan and include details on the sources of the non-Federal share of plan expenditures, as necessary. In addition, section 2107(e)(1)(C) of the Act provides that section 1903(w) of the Act (relating to limitations on provider taxes and donations) applies to States in the same manner under title XXI as it applies under title XIX. Because section 1903(w) of the Act prohibits States from collecting impermissible provider taxes and donations, and because the title XXI statute requires States to identify, in detail, sources of the States' share of expenditures, it is appropriate to evaluate the permissibility of the non-Federal funding sources involving health care-related taxes and/or donations prior to approval of a State plan and whenever the State changes its source of State funds. The method of evaluating the permissibility of State funding sources involving health care-related taxes and/or donations, as set forth at proposed § 457.60(a)(3), now § 457.60(c), is the most efficient mechanism to ensure protection to beneficiaries, Federal taxpayers, and States. However, it should be noted that if a State makes a programmatic change as a result of a change in the amount of the source of the State share, then it is required to submit a State plan amendment in accordance with § 457.60(b).

We believe it is our obligation to ensure the implementation of the congressional intent that States not use impermissible sources of funding for child health programs, as impermissible State funding would place a State's entire program at risk. Furthermore, it appears that Congress sought to avoid the process used in Medicaid of assessing penalties that may accumulate over a long period of time and the disruption in program operation that such penalties can create. By requiring a State to submit a State plan amendment for review, we have an opportunity to prevent the States' use of impermissible funding and any consequential disruption of the program. In the long run, the process better protects States' and the federal government's interest in assuring continuity and ongoing coverage of children.

Comment: A few commenters expressed their concern that the requirement at proposed § 457.60(b) for amended three-year budgets when States modify approved budgets creates a significant burden for both the States and HCFA. A State expressed the opinion that this requirement is particularly burdensome if applied to insignificant modifications to the approved budget.

Two commenters suggested that a three-year budget is difficult because ''State budget processes and legislatures do not always coincide with program decisions.'' Another commenter similarly noted that a three-year budget is longer than a State agency can reasonably determine at the time program decisions are made because the State portion of the budget is determined annually by the State legislature. An additional commenter stated that the requirement at proposed § 457.60(b) works against the budgetary processes currently in place at the State level, and that budgets are developed for two years into the future at most.

Several commenters argued that three year budget estimates will not be accurate, citing reasons such as the uncertainty caused by tremendous enrollment growth, changing populations, variations in State revenues, and unstable medical expenditures. Two States commented that three year budget estimates would not provide the level of information necessary to assure financial ability to support the program change, and would be of limited use because they would not reflect either actual expenditures or actual enrollment. These States thus

asserted that the stated rationale in the preamble, that such a projection would be useful to show if States plan to spend their money in the succeeding two years, will not apply.

One State asserted that there is no reason to look to Medicaid waiver processes for a model for SCHIP budget requirements, since the waiver process requires a demonstration of budget neutrality that is not necessary in SCHIP. This State argued that the model should be the title XIX State plan amendment process.

Some States suggested alternatives for the proposed requirement for three-year budgets with State plan amendments, such as an assurance of available funding; a three year budget with the annual report but not each State plan amendment; or a one-year budget rather than a three-year budget. Several commenters suggested that an amended three year budget should be required only when a State plan amendment would make a significant modification to the previously approved budget, such as a major change in the benefit package, eligibility rules, or cost-sharing.

Response: We agree with the commenters' concerns that the requirement for a three-year budget with a State plan amendment at proposed 457.60(b) creates an unnecessary burden for the States. Section 2107(d) requires that the State's description of the budget for its State plan be updated periodically as necessary. Because we otherwise require that the budget be updated periodically through the annual reports and through quarterly financial reporting, we have revised the requirement at proposed § 457.60(b), now § 457.60(d), to require that only a one-year budget be submitted with a plan amendment that has a significant impact on the approved budget. An amendment would have impact on the approved budget if it changes program elements related to eligibility, as required by § 457.60(b)(1) or cost sharing, as required by § 457.60(b)(6). We have also revised § 457.750 to reflect this change.

Section 457.140, will continue to require that the State submit a three-year budget with their annual report that describes the State's planned expenditures. Because States have up to three years to spend each annual allotment, a three-year budget is useful to show if States project that they will use their unused allotments in the succeeding two fiscal years. We realize that a State must base the required information on projections and that the budget projections submitted to HCFA are not approved by a State's legislature. We also recognize that projections of expenditures for a three-year period may vary from actual expenditures for a variety of reasons. Because SCHIP is a new program, States did not have experience at the beginning of the implementation of their programs to accurately predict enrollment of children or costs associated with providing services. However, we expect that as States gain experience in operation of their programs and as the State program rules stabilize over time, the three-year projections will become more accurate. A three-year budget helps the State plan program expenditures and helps HCFA to analyze spending and develop a responsive reallocation formula within the parameters of the statute.

The preamble for § 457.140 included a discussion of the budget projections required in other programs. We would like to clarify that this discussion was not intended to serve as a rationale for the requirement for a three-year projection of expenditures in the SCHIP program. This discussion was intended to demonstrate that we took the budgetary requirements of other programs into consideration as we determined our budget requirements for SCHIP.

8. Duration of State Plans and Plan Amendments (§ 457.65)

In § 457.65, we proposed that the State may choose any effective date for its State plan or plan amendment that is not earlier than October 1, 1997.

We noted in the preamble that a State may implement a State plan prior to approval of the plan but that any State that implements an unapproved State plan risks the possibility that the plan will not be approved as implemented. If a State implements a State plan prior to approval and it is approved, we also indicated in the preamble our interpretation that the State can receive Federal matching funds on a retroactive basis for expenses incurred (other than expenses incurred earlier than October 1, 1997) for the programs if the State operated in compliance with the approved State plan and all applicable statutory and regulatory requirements. In the event that the State plan is not approved, the Federal government would not match the State's prior expenditures for implementation of the State plan.

In the preamble to the proposed rule, we noted the risks involved in implementing a change in the State program without receiving prior approval of that change through a State plan amendment. If a State makes a change and the State plan amendment reflecting the change is later disapproved, the State may either risk its Federal matching or face a compliance action. The State cannot receive Federal matching for expenditures on a program change that is disapproved through the State plan amendment process if these expenditures can be segregated from expenditures on the approved State plan. The State would be subject to the compliance remedies described in section 2106(d) of the Act, as implemented in the final financial regulation (65 FR 33616), May 24, 2000, if the expenditures on such a program cannot be segregated from expenditures on the approved State plan. A compliance action is appropriate because the continued operation of the unapproved program change constitutes a failure to conduct the State program in accordance with the approved State plan.

Section 2106(b)(3)(C) of the Act provides that any State plan amendment that does not eliminate or restrict eligibility or benefits can remain in effect only until the end of the State fiscal year in which it becomes effective (or, if later, the end of the 90-day period in which it becomes effective) unless the State plan amendment is submitted to HCFA before the end of the period. We proposed to implement this provision at § 457.65(a)(2). Thus, if a State program change is implemented and the corresponding amendments are not submitted within the required time frame, the State risks being found out of compliance with its State plan and therefore, risks loss of Federal financial participation in expenditures beyond the scope of the approved State plan or other financial sanctions, as discussed in the final financial regulation (65 FR 33616), May 24, 2000.

Section 2106(d)(2) of the Act requires that the Secretary provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of an enforcement action. Thus, we proposed to clarify certain provisions set forth in HCFA 2114–F (65 FR 33616, May 24, 2000). Specifically, paragraph (d)(2) of § 457.204, ''Withholding of payment for failure to comply with Federal requirements,'' discussed the opportunity for correction prior to a financial sanction for failure to comply with a Federal requirement. As proposed, § 457.204(d)(2) provided that if enforcement actions are proposed, the State must submit evidence of corrective action related to the findings of noncompliance to the Administrator within 30 days from the date of the preliminary notification. In the SCHIP

programmatic regulation, we proposed to revise § 457.204(d)(2) to address in more detail the possible scope of corrective action that could be required. We proposed that corrective action is action to ensure that the plan is and will be administered consistent with applicable law and regulations, to ameliorate past deficiencies in plan administration, and to ensure equitable treatment of beneficiaries.

In accordance with section 2106(b)(3)(B)(ii) of the Act, at § 457.65(b), we proposed that an amendment that eliminates or restricts eligibility or benefits under the plan may not be effective for longer than a 60-day period unless the amendment is submitted to HCFA before the end of that 60-day period. We further proposed, in accordance with section 2106(b)(3)(B)(i), that amendments that eliminate or restrict eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law. The notice must be published prior to the requested effective date of change.

At § 457.65(c) we proposed that a State plan or plan amendment that implements cost-sharing charges, increases the existing cost-sharing charges or increases the cumulative cost-sharing maximum permitted under proposed § 457.560 is considered an amendment that restrict benefits and must meet the requirements of § 457.65(b).

At § 457.65(d), we proposed that a State plan amendment that requests approval of changes in the source of the State share of funding must be submitted prior to such change taking effect. With regard to source of funding, we stated that if a State has indicated that general revenues are the source of funding, then we would require a plan amendment for changes in the State's tax structure that reflect or include a change to general revenues based on health care related revenues used to finance the State's share of title XXI expenditures. We would not require a plan amendment to reflect changes in the type of non-health care related revenues used to generate general revenue.

In accordance with section 2106(e) of the Act, at § 457.65(e), we proposed that an approved State plan continues in effect unless the State modifies its plan by obtaining approval of an amendment to the State plan or until the Secretary finds substantial non-compliance of the plan with the requirements of the statute and regulations. An example of substantial non-compliance would be the imposition of cost-sharing charges that exceed Federal limits.

Comment: A few commenters expressed concern about the time frames for submission of State plan amendments. A commenter suggested that HCFA follow guidelines similar to Medicaid guidelines that allow a State to submit a plan amendment that is statutorily allowable in the quarter after the State's implementation of the change. Another commenter proposed that the time frames for submitting an amendment be the same regardless of whether the State plan amendment limits or restricts eligibility or benefits. In the view of this commenter, States are likely to make errors if the time frames are different.

Response: Section 2106(b)(3) of the Act provides specific time frames for submission of State plan amendments. A State plan amendment that does not eliminate or restrict eligibility or benefits can remain in effect until the end of the State fiscal year in which it becomes effective (or, if later, the end of the 90-day period in which it becomes effective) unless the State plan amendment is submitted to HCFA before the end of that State fiscal year or the 90-day period. This time frame is more liberal than the time frame under the Medicaid guidelines, which only permit a title XIX amendment to be effective from the first day of the quarter in which the amendment is submitted. Furthermore, under the statute, an amendment that eliminates or restricts eligibility or benefits under the plan may not be effective for longer than a 60-day period unless the amendment is submitted to HCFA before the end of that 60-day period. While we note the potential for confusion caused by two different time frames, section 2106(b)(3) of the Act explicitly provides for different time frames for different types of amendments and does not provide authority for a different process. States are encouraged to discuss planned amendments with HCFA to assure they are submitted in a timely manner.

Comment: One commenter appreciated HCFA's support for State flexibility in how to provide public notice of State plan amendments. Other commenters applauded HCFA's decision to treat State plan amendments that increase cost sharing as amendments that restrict ''eligibility or benefits.''

Response: We note the commenters' support.

Comment: One commenter requested that HCFA clarify whether it intends to require public notice when a family will experience an increase in its premium share because the subsidy rate is being applied to a premium that resulted from an insurance carrier rate increase. In this commenter's view, public notice is unnecessary in this situation because the State is not initiating the private sector rate increases. The State could continue to assure that the family's total cost sharing remains within Federal limits.

Response: A change in cost sharing that increases the amount of premium share owed by the enrollee, must be reflected in a State plan amendment that meets the requirements set forth in § 457.65(c). However, an increase in premium share that does not affect the enrollee's cost-sharing charges or that does not bring the cost sharing charges above the level reflected in the State plan would not be subject to the public notice requirements of § 457.65(b). We recognize that § 457.65(b) could be difficult to administer in States that provide premium assistance for coverage provided through group health plans, depending how a State chooses to design its premium assistance program. However, such an increase may impact the enrollee's access to services and participation in SCHIP and, consistent with the statutory requirements for amendments eliminating or restricting benefits at 2106(b)(3)(B), the public must be given notice prior to the increase. The statute does not provide an exception for coverage provided through group health plans.

However, a State has flexibility to design a system that will meet the prior public notice requirement. For example, a State may choose to require that the family be charged a fixed dollar amount, rather than a percentage of total premium, to hold constant the amount of premium share that the family is charged. Alternatively, a State may generally keep its charges for premium assistance programs below the level of cost sharing approved under the State plan to allow room for some cost-sharing increases that would not bring the charges above the level reflected in the plan. A State also may choose to establish a mechanism to be notified of increases prior to those increases taking effect so that it may provide prior public notice as required by § 457.65(b).

Comment: A commenter asked that HCFA clarify that ''cost sharing'' in this context is defined in the same way as it is in § 457.560 for purposes of imposing cumulative maximums.

Response: So that the term ''cost sharing'' has the same meaning throughout the final rule, we have added a provision in § 457.10 to define it to include premium charges, enrollment fees, deductibles, coinsurance, copayments, or other

similar fees that the enrollee has the responsibility for paying. However, we note that for purposes of the actuarial analysis required at § 457.431(b)(7), cost sharing includes only copayments, coinsurance and deductibles as described in the Notice of Proposed Rulemaking.

Comment: One commenter asked HCFA to clarify that amendments that lengthen or institute eligibility waiting periods of uninsurance or narrow exceptions to such waiting periods constitute amendments that affect ''eligibility or benefits.''

Response: To clarify that instituting or changing eligibility waiting periods without health insurance, narrowing exceptions to such periods, or changing open enrollment periods in a way that would further restrict enrollment in the program are considered to be State plan amendments that restrict eligibility, we have added a new paragraph (d) to § 457.65. This new provision specifies that a State plan amendment that implements eligibility waiting periods without health insurance; increases the length of existing eligibility waiting periods without health insurance; or institutes or expands the use of waiting lists, enrollment caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the public notice requirements set forth in this section. Eligibility waiting periods without health insurance and limited open enrollment periods are restrictions in eligibility because these enrollment procedures directly limit an enrollee's access to the program. We further clarified in § 457.305 that in the State plan, the State must include a description of the State's policies governing enrollment and disenrollment, including enrollment caps, process(es) for instituting waiting lists, deciding which children will be given priority for enrollment, and informing individuals of their status on a waiting list, if applicable to that State.

Comment: Many commenters expressed concern about whether the provision at § 457.65(b)(1) requiring States only to certify that they have provided public notice of such plan amendments ''in a form and manner provided under applicable State law'' provides meaningful public input into proposed State plan amendments. These commenters questioned whether ''notice'' provides the opportunity to comment on and discuss a proposal, and point out that the form of notice could prove largely meaningless, depending on a State's particular laws. Several commenters recommend that the final rule require States to certify that they have provided prior public notice and a meaningful opportunity for the public to submit comments on any proposed State plan amendments that affect eligibility or benefits. States have found such input to be helpful to identify ways in which the program can be improved and maintain strong support for the program. An additional commenter believed that State plan amendments to make changes in benefits require public notice and comment.

Response: We encourage States to obtain meaningful public input prior to submission of a State plan amendment that eliminates or restricts eligibility or benefits. Furthermore, we require, in § 457.120, that States involve the public once the program has been implemented. However, section 2106(b)(3)(B) of the Act specifically permits a State to certify that it has provided public notice of the change in a form and manner provided under applicable State law, and we believe the requirements under § 457.65 are consistent with the flexibility provided by this statutory provision.

Comment: One commenter requested that we clarify § 457.65(b)(1) to confirm that States must certify that they have complied with applicable State administrative procedure law or similar requirements mandating public notice and comment with respect to the promulgation of rules or regulations of general applicability. This commenter also requested modification of the provision to clarify that the State must certify that it has complied with all applicable State legal requirements for notice *and* a meaningful opportunity for public comment. Although State processes vary, this commenter indicated that there is generally a requirement that notice be issued for a specified period of time, followed by a period for public comment. This same commenter believes that § 457.65(b)(2), which requires that public notice be published before the effective date of the change, should be eliminated because it could be interpreted to allow State plan amendments that restrict or eliminate eligibility or benefits to become effective as long as the public notice was published before the requested date of the change, regardless of whether or not the State had provided meaningful opportunity for public comment or whether the applicable time frames had been met.

Response: As noted in the previous response, § 457.65(b)(1) implements section 2106(b)(3)(B) of the Act, which specifically permits a State to certify that it has provided prior public notice of the change in a form and manner provided under applicable State law. While we encourage States to consider public input, title XXI addresses only public notice as a condition for the effective date of certain State plan amendments. Our regulation is not intended to restrict notice and comment opportunities available under State law. We note that States must also comply with the requirements of § 457.120 regarding public involvement.

Comment: One commenter suggested that proposed and submitted State plan amendments be posted on the HCFA and State web sites. The commenter noted appreciation for the effort that HCFA has made to date to post information about the filing of State plan amendments on its web site and encourages the agency to modify the preamble to clarify that State plan amendments (along with State plans) will continue to be made available to the public through the HCFA web site. According to this commenter, the preamble should indicate that HCFA will post the actual plan amendments that are pending whenever possible and that, should this not be possible, the agency will list the name and phone number of a State official who can provide a copy of the pending State plan amendment.

Response: We will continue to make an effort, as resources permit, to make the approved State plan and any approved State plan amendments available to the public on the web site. However, we do not post pending State plan amendments on the web site because amendments are often altered during the approval process, and this may cause confusion to the public, although we will consider identifying on the HCFA web site whether a State has a pending plan amendment under review. The position title of the State official responsible for program administration may be found in the approved State plan. Also posted on the HCFA web site is a list of HCFA contacts for each State's SCHIP program.

Comment: Over a dozen commenters opposed the proposed provision at § 457.65(d) to require prior approval of a plan amendment regarding a States' share of program funds and requested that this requirement be withdrawn. According to these commenters, section 2106 of the Act contemplates a process under which States can specify the effective date of their plans or amendments and, if a plan is approved, a State can receive matching funds on a retroactive basis. In these commenters' view, the statute sets forth straightforward limits on a State's flexibility to specify effective dates, but those limits do not contemplate prior

approval of an amendment. The commenters asserted that the statutory scheme provides adequate remedies for the Secretary if the plan or plan amendment is subsequently disapproved.

Response: We believe the commenters' concerns may be based in a misunderstanding of the process. The requirement at proposed § 457.65(d) does not prevent States from implementing a new source of funding prior to receiving State plan or plan amendment approval. It requires that an amendment be submitted before the change can be implemented, but the amendment does not need to be approved in order for a State to receive matching funds for expenditures relating to the change. A State can submit its amendment on January 1, begin using the new source of funding on February 1, and receive matching funds retroactive to February 1 if the amendment is approved on or after that date.

The requirement at § 457.65(e) ensures that the time period during which a State may operate a program using impermissible funds is limited to the time during which the amendment is under review. HCFA can only approve a State plan amendment to the extent that the source of funding is considered permissible. Thus, while a State may implement a new source of funds prior to receiving State plan approval, the Federal matching funds are at risk until a determination of permissibility has been made. To the extent that source is determined to be impermissible, the State plan amendment would be disapproved and the State would realize the penalty against its SCHIP expenditures in accordance with the statutory penalty provisions. We expect that the required process will protect States from proceeding too far using impermissible State funds, and from thereby placing these programs and enrollee coverage at risk. Furthermore, a State is not required to submit a State plan amendment for changes in the source of general revenues used to fund SCHIP, as long as those changes are not affected by health care-related taxes or donations. For further rationale on our policy requiring amendments on changes in the source of State funding, please see earlier comments on § 457.60.

Comment: Several commenters asserted that the proposed § 457.65(d) intruded on State budgeting and financial prerogatives, was contrary to practices in other federal-state matching programs, and could not have been intended by Congress. One commenter did not understand why the Federal government wants prior approval of increases in State commitments under title XXI when Congress has provided States with firm allotments for at least five years. Several commenters noted that it may not be possible for the State to submit a State plan amendment to HCFA before the effective date of any change in the source of the State share of funding becomes effective because of the legislative budgeting cycle, which sometimes includes supplemental funding for incurred expenditures or legislation with a retroactive effective date to take advantage of previously unavailable funds.

Response: It is important to note that § 457.65(d) does not require prior approval of new State funding sources. We recognize that § 457.65(d) may reduce State flexibility, we must also consider the statutory penalties for the use of impermissible provider taxes and donations as specified in section 2107(e) and the public interest in assuring that States do not find themselves in a situation where they have been operating with impermissible funding sources for an extended period of time. Congress specifically imposed penalties for the use of impermissible funds and the process established by these rules protect States and SCHIP programs from the risk of a significant penalty that could make it difficult for the State to continue to operate its program for children. In light of the effective statutory prohibition on the use of these funding mechanisms, we do not believe we are unduly intruding on the States budget process through this requirement, as we are not questioning State legislative appropriations that are not derived from health care-related taxes or donations. A State is not required to submit a State plan amendment for changes in the sources of general revenue used to fund SCHIP, when those changes are not affected by health care-related taxes and donations. By reviewing the State source of funding, we have the opportunity to prevent the kind of disruption to ongoing program operations that could occur if a State was found to have used an impermissible source of funding for an extended period of time.

Comment: One State expressed its view that the proposed requirement of prior approval for SCHIP funding changes is not feasible given the State's commitment to developing a public/private partnership with private donors. The State indicated that it waited almost a year for approval from HCFA to be able to accept a contribution from a private foundation. This State asserted that this requirement would hinder the State's ability to accept contributions from private sources.

Response: States are not required to obtain approval of the State plan amendment prior to a change taking effect. Thus, we do not believe that the process will hinder States' ability to accept contributions from private sources. States are required by § 457.65(e) to submit a State plan amendment prior to a change in State source of funding taking effect. While any delay in approving the amendment would not affect a State's ability to rely on such funds, at its own risk pending review, we agree that HCFA should act in an expeditious manner to review these amendments. The statutory requirements governing contributions received by States are very restrictive and we have the responsibility to ensure that contributions received by States from private sources comply with these statutory requirements. Federal regulations require that we evaluate contributions received by States on a case-by-case basis. States must submit necessary documentation to us in accordance with the Federal regulations so that we may evaluate the permissibility of a contribution. That documentation is related to the nature of the contributor's business and financial characteristics, including the source of its annual revenues. We will make our best effort to determine the permissibility of a contribution promptly once a State has provided the information that we need to make a determination.

Comment: One commenter requested clarification of the exemption at § 457.65(d)(2) to the general requirement for the submission of State plan amendments relating to changes in the source of State funding for ''non-health care related revenues.'' The commenter stated that clarification is necessary to ensure that, for example, income tax receipts from medical professionals are not considered ''health care related revenues.''

Response: Taxes of general applicability are not considered ''health care-related'' for purposes of section 1903(w) of the Social Security Act, and the term has the same meaning under § 457.60(a)(3). (As noted earlier, § 457.65(d)(2) has been combined with 457.60(a)(3) for better organization of the regulation.) However, section 1903(w)(3)(A) of the Act and the Federal regulations implementing it at 42 CFR 433.55 specify that a tax will be considered to be health care-related if at least 85 percent of the burden of the tax falls on health care providers. These provisions further state that a tax is considered to be health care-related if

the tax is not limited to health care items or services, but the tax treatment of individuals or entities providing or paying for those health care items or services is different than the treatment provided to other individuals or entities.

Comment: One commenter suggested adding a new provision to proposed § 457.65(e), now § 457.65(f), to clarify that a State could discontinue its program by withdrawing its State plan.

Response: As set forth in § 457.170, a State may request withdrawal of an approved State plan by submitting a State plan amendment to HCFA as required by § 457.60. We note in § 457.170 that because withdrawal of a State plan is a restriction of eligibility, a State plan amendment to request withdrawal of an approved State plan must be submitted in accordance with requirements set forth in § 457.65(b), including those related to the provision of prior public notice. We have not added a new provision to proposed § 457.65 because we do not find it necessary to repeat this State option elsewhere in the regulation text.

9. Program Options (§ 457.70)

Under section 2101(a) of the Act, a State may obtain health benefits coverage for uninsured, low-income children in one of three ways: (1) a State may provide coverage by expanding its Medicaid program; (2) a State may develop a plan providing coverage that meets the requirements of section 2103 of the Act; or (3) a State may provide coverage through a combination of a Medicaid expansion program and a separate child health program. We set forth the program options at proposed § 457.70(a).

At § 457.70(b), we proposed that a State plan must include a description of the State's chosen program option.

At § 457.70(c)(1), we proposed that the following subparts apply to States that elect Medicaid expansions:

- Subpart A.
- Subpart B (if the State claims administrative costs under title XXI).
- Subpart C (with respect to the definition of a targeted low-income child only).
- Subpart F (with respect to determination of the allotment for purposes of the enhanced matching rate, determination of the enhanced matching rate, and payment of any claims for administrative costs under title XXI of the Act only).
- Subpart G.
- Subpart H (if the State elects the eligibility group for optional targeted low-income children and elects to operate a premium assistance program).
- Subpart J (if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims based on a community based health delivery system).

We proposed that subparts D, E, and I of part 457 do not apply to Medicaid expansion programs because Medicaid rules govern benefits, cost sharing, program integrity and other provisions included in those subparts. We note that the provisions of subparts B and F were set forth in the May 24, 2000 final rule (HCFA 2114–F, 65 FR 33616).

In addition, at proposed § 457.70(c)(2), we specified that States choosing a Medicaid expansion program must submit an approvable amendment to the State's Medicaid State plan, as appropriate.

At § 457.70(d), we proposed that a State that chooses to implement a separate child health program must comply with all the requirements in part 457.

At 457.70(e), we proposed that a State that elects to obtain health benefits coverage through both a separate child health program and a Medicaid expansion program must meet the requirements of (c) and (d) of this section.

Comment: While the statute specifies that States have the option of implementing their SCHIP programs as Medicaid expansions, State-only programs, or a combination of the two, a commenter contended that the regulations favor States that have elected to use title XXI to expand their Medicaid programs by imposing greater administrative burdens on separate child health programs.

Response: We do not agree that the regulations favor States that choose the Medicaid expansion option. Certain provisions in part 457 do not apply to Medicaid expansion programs because Medicaid rules govern those aspects of program operations. Furthermore, we do not believe that we have imposed greater administrative burdens on States that choose to implement separate child health programs. The regulations set forth in part 457 are consistent with the State options provided by title XXI and are important to ensure the efficient and effective administration of SCHIP. We have worked to ensure flexibility for States that wish to create separate child health programs within the parameters of the statute.

Comment: One commenter noted that § 457.70(c)(1)(vi) should be deleted because Subpart H only applies to separate child health programs. Another commenter said that the language of Section 457.70 should be clarified so that readers do not assume incorrectly that States that choose to develop separate programs must adhere to all Medicaid rules.

Response: We agree with the commenter that Subpart H does not apply to Medicaid expansion programs and have thus deleted § 457.70(c)(1)(vi) of the proposed regulation and renumbered the subsequent provision accordingly. Subparts C, D, E, H, I, and K of part 457 do not apply to Medicaid expansion programs because Medicaid rules govern the areas addressed by those subparts. A State that chooses to implement a separate child health program must comply with all the requirements in part 457 and is not required to comply with the requirements in title XIX, other than those specifically noted in § 457.135. We believe that § 457.70 clearly sets forth the applicable requirements for the respective program types. It should also be noted that because we no longer reference Subpart C in § 457.229, we have also deleted proposed § 457.70(c)(i)(iii).

10. Current State Child Health Insurance Coverage and Coordination (§ 457.80)

In accordance with sections 2102(a)(1) and (2) and 2102(c)(2) of the Act, we proposed to require that the State plan describe the State's current approach to child health coverage and its plans for coordination of the program with other public and private health insurance programs in the State. In proposed paragraphs (a) through (c), we specified that the State must provide a description of the following:

- The extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children, by income level and other relevant factors, currently have creditable health coverage (as defined by § 457.10) and, if sufficient information is available, whether the creditable health coverage they have is under public health insurance programs or health insurance programs that involve public-private partnerships.
- Current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships.
- Procedures the State uses to accomplish coordination of the program under title XXI with other public and private health insurance programs, including procedures designed to increase the number of children with

creditable health coverage, and to ensure that only eligible targeted low-income children are covered under title XXI.

Comment: One commenter noted that HCFA should not require States to gather data on other creditable health coverage available in the State as proposed in § 457.80(a). While useful, this information is not critical to the successful implementation of a SCHIP and its collection may actually divert resources from SCHIP.

Response: Section 2102(a)(1) of the Act requires that the State plan include a description of the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children, by income level and other relevant factors, currently have creditable health coverage. Section 457.80(a) implements this statutory requirement. States do not necessarily have to generate new data to meet this requirement, but can rely on other data sources that may be available. Knowledge of the availability of creditable health coverage will help a State determine how best to design and to implement its SCHIP program and outreach strategies.

Comment: Several commenters requested that HCFA add to the categories of children for which it requests coverage information in § 457.80(a). Two commenters request that HCFA add ''migrant and immigrant status'' to the sentence in the preamble highlighting the categories that States might find useful in describing current availability of health insurance. In these commenters' view, migrant and immigrant children are especially susceptible to being without health insurance, and the Immigration and Naturalization Service recently clarified in its ''public charge'' guidance, issued in a Notice of Proposed Rulemaking (64 FR 28675, May 26, 1999) and an accompanying Memorandum published the same day (64 FR 28689), that receipt of health benefits will not harm one's chances for legal immigration. Another commenter recommended that the required factors include ''suburban'' in addition to the age group, race and ethnicity, and rural/urban categories already listed in the preamble because suburban areas across the county have a growing number of low-income and uninsured families.

Another commenter suggested that HCFA require that the State plan include a description of the extent of coverage by race, ethnicity, and primary language spoken. According to this commenter, it is now well-established that minority children are more likely than non-minority children to lack health insurance. In this commenter's view, collection of the data also gives HHS the tools needed to monitor and enforce title VI of the Civil Rights Act of 1964.

One commenter recommended that ''other relevant factors'' be clarified and several other commenters believed the list should include primary language, because children with limited English proficiency are at high risk of being uninsured.

Response: We encourage States to include a description of as many relevant categories of children in the State plan as possible, to the extent that data are available. We agree that more detailed data classifying children is useful to learn more about the health care coverage status of the children in the State, but recognize that States may have limited data sources and that some categories have more relevance than others, depending on the State. Because of the potential limited availability of this information at the outset of a program, we are retaining the flexibility in § 457.80(a) for a State to describe in the State plan the classes of children for which it has data available. We note, however, that we have added a provision in Subpart G, Strategic Planning, that requires States to report data on the gender, race and ethnicity of enrollees in their quarterly enrollment reports. In addition, States will be required to report information on the primary language of SCHIP enrollees in their annual reports.

We are not adopting the commenter's recommendation to require information for specific categories of children in the regulation. This provision requires that a State describe coverage provided to children at the beginning of implementation of its program. We recognize that States may have limited resources available at that time and request that they provide information sufficient to illustrate that the State has analyzed the extent of uninsurance among children in the State using available data sources.

Comment: One commenter interpreted § 457.80(b) to require a State to take steps to get uninsured children enrolled in public and private health insurance programs. In this commenter's view, families should have a choice of where to get coverage and States should therefore be allowed to inform families of coverage options and, upon request, assist in helping families with choices made.

Response: Section 457.80(b) requires that a State plan include a description of the current State efforts to provide or obtain creditable health coverage for uncovered children. This provision does not require that a State take particular steps to identify and enroll children in public and private health insurance programs, but rather to describe its efforts. However, States are required by §§ 457.350 and 457.360 to screen for Medicaid eligibility and to have procedures to ensure that children found through the screening process to be eligible for Medicaid apply for and are enrolled in Medicaid.

Comment: One commenter described its view that HCFA is creating unnecessary obstacles in these regulations to creating public-private partnerships. This commenter believes that one reason States have problems getting providers to participate in their programs is that many providers do not want to respond to the various idiosyncrasies of government programs such as the ''unnecessary'' paperwork and the ''awkward'' procedures that no other payor or insurance company requires. The commenter believes that these problems help stigmatize government programs and can cause well-intentioned providers to opt out of participation in SCHIP or other government programs. According to this commenter, providers that remain may develop negative attitudes about the program that transfer into negative attitudes about the participants, who may leave the program. To solve this problem, many States (including this commenter) have tried to address these and other stigma issues by creating separate child health programs that are more similar to private sector models and more familiar to providers and enrollees.

Response: The provisions set forth in this regulation are necessary to implement title XXI and are not intended to create obstacles to public-private partnerships. Title XXI and this final regulation provide States with significant flexibility in designing separate child health programs and we do not believe that federal rules are preventing States from employing procedures that address negative perceptions about public programs that may exist among providers. As noted in § 457.940, States have flexibility to set payment rates for providers and should do so in a manner that will attract a sufficient number and scope of providers that will adequately serve the SCHIP population. We believe this final rule confirms HCFA's commitment to working with States to establish and maintain programs that are not unduly burdensome to administer and accomplish the goal of providing needed health benefits coverage to children and families.

Comment: The preamble to § 457.80(b) explains that HCFA proposes to require States to provide an overview of current efforts made by the State to obtain coverage for children through other programs, such as WIC and the Maternal and Child Health Block Grant Program. Several commenters stated that although these programs offer health care or health-related services, they are not considered to be health insurance coverage programs, and requiring a description of coordination with these other programs in the State exceeds the scope of the SCHIP statute. Another State commented that describing the outreach and coordination efforts of all the other existing health programs would be extremely burdensome and should not be required.

One commenter supported the requirement of coordination between SCHIP and other publicly funded programs that provide coverage to uninsured children but expressed concern with an overly broad and burdensome requirement that puts States in the potential position of acting as unlicensed insurance agents or brokers to link consumers with private creditable coverage. One State expressed that HCFA should more clearly define what is meant by ''coordination with other public and private health insurance programs.'' In defining this term, HCFA should keep in mind that, especially in large States, staying involved in all parts of the private insurance market is a challenging task.

One commenter recommended that the Child Support Enforcement (CSE) program be included in the coordination provision at § 457.80(c) because CSE needs to be made aware of children in the CSE caseload who are covered by SCHIP. Another commenter noted that SCHIP enrollees may benefit from the services offered by a State child support program, and that families need to understand options related to obtaining or enforcing child support and medical support orders.

Response: We are responding to the comments requesting clarification of the required State plan provisions on coordination with other public and private health coverage programs by revising our proposed regulatory language to better reflect our intent and purposes. As described in the preamble, § 457.80(c) is meant to reflect the coordination requirements of Sections 2101(a), 2102(a)(3), and 2102(c)(2) of the Act. Section 2101(a) requires that in using title XXI funds to expand coverage to uninsured populations, this effort be ''coordinated with other sources of health benefits coverage for children.'' Section 2012(a)(3) of the Act requires that a State plan describe how the plan is designed to be coordinated with such efforts to increase coverage under creditable health coverage. As provided by section 2102(c)(2) of the Act, the plan must also describe the coordination of the administration of the State program under this title with other public and private health insurance programs.

In accordance with these requirements, we have revised § 457.80(c) to clarify that the State plan must include a description of the procedures the State uses to coordinate SCHIP with public and private health insurance and ''other sources of health benefits coverage'' for children. ''Other sources of health benefits coverage'' would include WIC and Maternal and Child Health Programs. Section 2108(b)(1)(D) of the Act supports this clarification. This section requires an assessment of State efforts to coordinate SCHIP with ''other public and private programs providing health care and health care financing including ''Medicaid and maternal and child health services.''

As noted in the preamble to the proposed rule, additional examples of sources of health benefits coverage could include community and migrant health centers, Federally Qualified Health Centers, Child Support Enforcement Programs, and special State programs for child health care. These can all be important sources of health benefits coverage for children. This list of examples is not intended to be an exhaustive list of those programs that a State should coordinate with its SCHIP program and describe in its State plan. We are not providing a specific list because we recognize that States are different and that it is important to respect the variety of programs and coverage plans that operate in each State. The State should describe its relationships with other State agencies, low-income community organizations, and large insurance providers in the State that provide health insurance or health benefits to children. For example, if a State has a high risk insurance pool program, it should describe the coordination between this program and SCHIP; however, not all States have such insurance pools and the nature of these pools will vary among States.

Each State has a unique relationship with Federally Qualified Health Centers (FQHCs) and we believe that the flexibility of the State to structure these relationships should be maintained. Therefore, we have not required specific enrollment coordination procedures with FQHCs. However, we recognize the importance of enrolling SCHIP and Medicaid eligible children at sites where they typically receive care, such as FQHCs. Due to this relationship, FQHCs are vital partners in outreach and enrollment for this population. We encourage States to utilize these facilities in their outreach efforts.

These coordination provisions should not be interpreted to mean that we are requiring any particular effort on the part of the State to enroll children in private coverage.

Comment: One commenter indicated that it is extremely important for the regulations to specify what steps States must take in order to satisfy the requirement that separate child health programs be coordinated with existing Medicaid programs (including, for example, coordination of outreach and education efforts, screen and enroll requirements, transitioning from coverage under one program to the other, etc.). This commenter also recommended that the regulations require States to provide training to eligibility determination workers in both programs (as well as other workers) to ensure that appropriate transitions are made.

Several commenters believed that § 457.80(c) of the regulation (and not just the preamble to that section) should require States to describe the specific steps they will take to ensure that children who are found ineligible for Medicaid (at initial application or at redetermination) are provided with the opportunity to be enrolled in SCHIP. Another commenter pointed out that neither title XXI nor the proposed regulations take into consideration the movement of children between title XXI and title XIX programs as their eligibility status changes, nor have the Medicaid regulations been updated to reflect this possibility. A couple of these commenters suggested that perhaps the Medicaid regulations should be amended to address this issue. Another commenter believed that States should be required to describe how they will monitor these processes.

Several commenters indicated that the regulations should address the coordination of enrollment procedures for Medicaid and SCHIP at Federally Qualified Health Centers (FQHCs).

Response: We have taken the first commenters' suggestion into consideration and have revised the regulation at § 457.80(c) to refer to the requirements in §§ 457.350 and 457.360. States that implement separate child health programs are required to meet the requirements of §§ 457.350 and 457.360. States that implement separate child health programs and States that implement Medicaid expansion

programs must both describe the procedures for coordination required by § 457.80(c); however, the ''screen and enroll'' requirements of §§ 457.350 and 457.360 are not relevant or applicable to States that implement Medicaid expansions.

We agree that some more specificity with respect to the specific steps States must take to coordinate with Medicaid programs would be helpful in providing more clarity for States. At the same time, we believe that States need to retain the flexibility in coordinating SCHIP and Medicaid particularly in light of the specific administrative structures of the States' programs.

We agree with the commenters that the regulation should be revised to require States to describe in the State plan procedures to ensure that children who are found ineligible for Medicaid are provided the opportunity to be enrolled in SCHIP. We have revised § 457.80(c) to require that the State plan include a description of procedures designed to assist in enrolling in SCHIP those children who have been determined ineligible for Medicaid. This should occur both at the time of application and at the time of redetermination. The Medicaid regulations do not need to be amended because title XXI and these implementing regulations require coordination between SCHIP and Medicaid. We believe that State efforts to coordinate SCHIP with other public programs should include efforts to ensure that these processes are effective and have modified the Medicaid regulations at § 431.636 accordingly. In addition, we expect States to have mechanisms to evaluate the effectiveness of coordination between the two programs, as noted in § 457.350(f)(2)(i)(C).

11. Outreach (§ 457.90)

In § 457.90, we proposed to require a State to include in its State plan a description of the outreach process used to inform families of the availability of health coverage programs and to assist families in enrolling their children into a health coverage program pursuant to section 2102(c) of the Act. At proposed § 457.90(b), we set forth examples of outreach strategies including education and awareness campaigns and enrollment simplification. We discussed these outreach strategies in detail in the preamble to the proposed rule.

Comment: Many commenters expressed support for the requirement of outreach procedures and the examples provided. One commenter strongly supported the requirement that would require States to identify outreach procedures used to inform and assist families of children likely to be eligible for child health assistance under SCHIP or under other public/private health coverage programs. Another commenter supported the requirement of outreach strategies including education and awareness campaigns and enrollment simplification. Yet another commenter supported a streamlined application and enrollment process as a practical means of enhancing participation by qualified children, thereby increasing demand for needed medical and dental services.

Response: We note the commenters' support.

Comment: One commenter appreciated the efforts of HHS to maintain flexibility for the States in the outreach area as each State has established and continues to refine state-specific outreach efforts to identify SCHIP and Medicaid eligible children in their communities.

Response: We note the commenter's support.

Comment: One commenter suggested that we provide more examples of effective outreach. The commenter noted that States are being very creative in how they are conducting outreach and the two examples listed do not even ''touch the tip of the iceberg''.

Response: There are many examples across the nation of successfully implemented, locally developed outreach campaigns. Because there are so many effective approaches for outreach, it is impracticable to list them in this regulation. Our intention was not to provide an exhaustive list of effective outreach methods in the preamble, but to highlight examples of a few major types of outreach strategies. HCFA, along with HRSA and other public agencies and private organizations, will continue to facilitate the sharing of ''best practices'' through information sharing sessions, technical assistance and guidance separate from this document.

Comment: One commenter expressed that outreach is critical to the success of SCHIP. This commenter noted that the State of Colorado has done a good job of disseminating information to the public that is easily understood.

Response: We agree with the commenter that outreach is critical to the success of SCHIP and it is for this reason that we included the requirements in § 457.90.

Comment: One commenter suggested that the discussion of outreach in the preamble to the proposed rule should have referred to ''migrant and immigrant populations'' instead of just ''migrant populations'' because of the importance of outreach for immigrants.

Response: States may choose to target outreach activities to special audiences known to have large numbers of uninsured children, such as migrant and immigrant populations, as well as other groups.

Comment: One commenter suggested that the discussion in the preamble to the proposed rule of the role of ''clinics'' should have included ''Community Health Centers, Rural Health Centers, and other community-based clinics that provide a large proportion of care to uninsured patients'' in the list of providers that States should consider for distributing SCHIP information.

Response: The list of providers through which States could distribute program information was not intended to be exhaustive. We encourage States to distribute information through any provider that has the potential for reaching uninsured children, including community health centers, rural health centers, and other community-based clinics.

Comment: One commenter recommended that HCFA encourage States to involve community-based organizations in application assistance activities and describe the available sources of Federal funds for these activities. The commenter noted that there are numerous examples of staff at community based organizations being trained to conduct initial processing of applications for both Medicaid and separate SCHIP programs. Another commenter suggested we add to the examples of organizations listed as potential partners with the State those community-based organizations with expertise in doing outreach to, and providing services to, specific ethnic communities. This commenter also recommended that § 457.90(b) be amended to add examples of using community-based organizations. Another commenter noted that community-based organizations, including migrant and community health centers, are important outreach sites for reaching members of the Hispanic community. According to this commenter, Hispanic community-based organizations could coordinate with community centers, churches, Head Start, GED, Job Corps and WIC offices, and locations such as grocery stores, pharmacies, and other commercial centers as well.

Another commenter noted that many of the enrollment simplification methods, including outstationing of enrollment workers, are key to reaching more families, including families of children with special needs. States need

to be versatile in utilizing community-based organizations to help spread the word of the program to reach enrollment goals, according to this commenter. This commenter indicated that mechanisms for explaining the importance of health coverage helps families recognize the benefits of health insurance for their children.

Response: We encourage States that implement separate child health programs to involve community-based organizations in application assistance activities. States that implement Medicaid expansions must follow all Medicaid rules relating to eligibility determinations, but are encouraged to use community-based organizations to help reach and assist low-income uninsured children to become enrolled. States can receive Federal matching funds for outreach activities; for States that establish separate child health programs, outreach matching funds are subject to the 10% limit on administrative expenditures.

State experience shows that one of the most effective methods for reaching ethnic groups is through community-based organizations. Not only are the employees of these organizations familiar with the language and culture of the groups they serve, they are trusted members of the community. We strongly encourage the use of community-based organizations with expertise in serving specific ethnic communities as part of an effective outreach campaign.

We agree that outstationing enrollment workers is an important method of reaching uninsured children and enrolling eligible children into SCHIP and Medicaid. Education and awareness campaigns and enrollment simplification procedures have proven to be highly effective strategies for successful outreach. Because there are so many effective methods of outreach, such as using community-based organizations and outstationing enrollment workers, we have not provided an exhaustive list in the regulation.

Comment: One commenter urged that dentists also be listed as participants in education and awareness campaigns, as well as State and local dental and pediatric dental societies.

Response: We encourage States to disseminate information through all providers that serve uninsured children.

Comment: One commenter suggested that HCFA discuss using the CDC's Immunization Registries to assist States in identifying families with uninsured children. In planning to transition away from the use of immunization clinics towards integrating immunizations as part of well-child care, we will have to pay more attention to potential financial barriers which could be appropriately addressed by linking immunization outreach to SCHIP/Medicaid outreach efforts.

Response: Several data sets are available to assist States in the identification of families of uninsured children, including the CDC's Immunization Registries. States should strive to link health coverage program outreach with other forms of health-related outreach in the State, such as immunization outreach.

Comment: One commenter believed States should use public benefit programs that serve low-income families with children to inform families about the availability of health coverage. The discussion regarding the use of existing ''data sets'' to identify uninsured children who are potentially eligible for coverage under Medicaid or SCHIP identifies the school lunch program participant lists as one of the sources. The commenter noted that the school lunch program only identifies low-income children, not specifically uninsured low-income children.

Response: We encourage the use of public benefit programs that serve low-income families to identify children who may be eligible for SCHIP or Medicaid, subject to applicable confidentiality rules. We appreciate the commenter's note that school lunch programs do not identify uninsured low-income children. We support the use of school lunch program participant lists, and other sources that assist in the identification of low-income families and inform them of potentially eligible children of the availability of SCHIP or Medicaid. Of course, in using these source of information, States must comply with applicable laws and should ensure confidentiality.

Comment: A few commenters believed that outreach strategies should be targeted specifically to adolescents and to their families. One commenter recommended the inclusion of the term ''age'' in giving examples of ways to reach diverse populations, and a distinction should be made between young children and adolescents. Other commenters believed that initiatives should include specific elements designed to reach underserved adolescent population such as runaway and homeless youth, youth in foster care or leaving state custody, immigrant youth, pregnant and parenting adolescents, and others. The commenters urged HCFA to encourage States to work with consumer groups and adolescent-oriented service providers to develop adolescent-specific outreach strategies and materials. One commenter believed the list of suggested outreach sites should also include as broad a range of adolescent-specific sites as permitted by Federal law. Adolescent medicine and service providers such as school-based health centers, family planning and STD clinics, Job Corps Centers, community colleges, summer job programs, and teen recreation centers should be added to the list of members of the provider community who can distribute program information.

Response: Adolescents under the age of 19 are included in the term ''child'', which is defined in § 457.10 as an individual under the age of 19. States may implement outreach initiatives that are specifically designed to reach different targeted subpopulations, such as adolescent, runaway and homeless youth, youth in foster care or leaving state custody, immigrant youth, and pregnant and parenting children. We encourage States to disseminate information through providers, such as those listed by the commenter, that serve targeted subpopulations.

Comment: One commenter supported HCFA's decision to emphasize the particular importance of using the provider community to target education and awareness campaigns to families of newborns in the preamble to the proposed regulation. This commenter urged HCFA to include language that also stresses the importance of targeting pregnant women with education and outreach campaigns to facilitate prompt enrollment of newborns and their siblings.

Response: We encourage States to target special audiences, such as pregnant women and families of newborns, in their development of comprehensive education and awareness campaigns. Pregnant women and families of newborns will benefit from educational programs designed to inform them of the advantages of enrolling eligible newborns and other children in the family in health insurance, including obtaining well-baby care, well-child care and immunizations.

Comment: One commenter suggested that HCFA encourage States to provide materials and or eligibility workers to child care programs to identify and assist families of uninsured children served by the programs, as well as uninsured children of the programs' employees. These should include regulated and unregulated family-based child care providers as well as center-based facilities.

Response: We encourage States to disseminate information through child care programs and, when practicable, to

outstation eligibility workers at child care provider sites.

Comment: One commenter supported the inclusion in the proposed regulation text of language regarding education and awareness campaigns including targeted mailings and enrollment simplification. This commenter strongly urged HCFA to strengthen this section by requiring that States report to HCFA steps they have taken to simplify enrollment.

Response: We note the commenter's support of the proposed regulation language regarding education and awareness campaigns. We clarified in § 457.305 that States must describe in their State plan, policies governing enrollment and disenrollment, including enrollment caps, process(es) for instituting waiting lists, deciding which children will be given priority for enrollment, and informing individuals of their status on a waiting list. However, we are not requiring States to report on their mechanisms for simplifying enrollment beyond the requirement under § 457.90 to include a description of outreach procedures in their State plan. We also anticipate that States may include information regarding enrollment simplification in their annual report's description of successes and barriers in State plans design and implementation and approaches under consideration to overcome these barriers. We will continue to work with the States in a collaborative way to provide technical assistance and share information on successful enrollment mechanisms to encourage States to simplify enrollment.

Comment: One commenter recommended that HCFA emphasize the use of a simplified application system. This commenter noted that a simplified system makes it easier for a State to coordinate its Medicaid and separate SCHIP programs and is an essential ingredient for successful outreach.

Response: A major key to successfully reaching and enrolling uninsured children in SCHIP and Medicaid is a simple application process. We wish to emphasize that a simplified application process is vital to successful outreach and have included a reference to simplified or joint application forms in § 457.90(b)(2) as examples of outreach strategies States could employ.

Comment: One commenter recommended that HCFA place a limit on the number of pages of the individual State applications. The commenter noted that HCFA should also require that States provide joint Medicaid and SCHIP applications to reduce the paperwork on the part of the applicant as well as the eligibility workers, and to ensure that applicants are registered for the appropriate program.

Response: We disagree with the commenters' recommendations to limit the length of the applications and to require joint applications. As noted in the previous response, we strongly encourage a simplified application process and the majority of States with separate child health programs have developed joint applications. However, rather than prescribing specific outreach and application methods for all States, we are partnering with States to encourage the most effective approaches in each State.

Comment: A few commenters strongly encouraged States to conduct coordinated outreach campaigns that help families understand their children's potential eligibility for regular Medicaid or SCHIP-funded coverage. They urged that HCFA make clear that comprehensive statewide education campaigns are needed to inform the public about the availability of both SCHIP and Medicaid, and how to enroll eligible children in both programs. In addition, the commenters recommend reversing the order of the first and second paragraphs of the response. Similarly, they suggested that the list of ''enrollment simplification'' strategies should emphasize that these steps can be taken in Medicaid, as well as in separate SCHIP programs.

Response: We share the commenters' interest in, and commitment to, enrolling uninsured children in both Medicaid and SCHIP. We agree that a comprehensive, Statewide education campaign is needed to inform the public about the importance of the availability of both SCHIP and Medicaid. Virtually all of the steps that States have taken to implement simplified application procedures in separate child health programs can be taken in Medicaid, such as simplifying the application form, streamlining verification requirements, and eliminating any assets test. However, different rules apply in Medicaid with respect to who must make the final eligibility determination. While enrollment simplification in Medicaid is very important, it is not appropriate to address this particular issue in further detail in this final SCHIP rule.

As required by section 2102(c) and implemented in § 457.90, a State must inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs of the availability of the programs, and must assist them in enrolling their children in such programs. Medicaid is one of these other public health coverage programs. Furthermore, section § 457.80(c) requires that the State plan describe the State procedures to coordinate SCHIP with other public health insurance programs. Again, Medicaid is considered a public health insurance program.

We also note that the way in which States design their outreach initiatives has potential fiscal implications. Medicaid provides a federal match for States' expenditures associated with outreach to Medicaid-eligible children. SCHIP funds may be used to pay for outreach to SCHIP-eligible children (subject to the 10% limit on administrative expenditures). Because all children who apply for SCHIP must be screened for Medicaid eligibility (as required by § 457.350), outreach targeted to children likely to be found eligible for SCHIP likely also will reach children eligible for Medicaid.

Comment: Several commenters suggested that bilingual outreach workers, linguistically appropriate materials, and culturally appropriate strategies must be provided when needed. One commenter noted that HCFA should elaborate on Title VI's mandate for linguistic access to services and give examples of how States and contracted entities can comply with this mandate. One commenter recommended that HCFA specify that States must provide access to linguistically and culturally appropriate health care services. In this commenter's view, States should be required to provide all written materials and application assistance in all applicable languages. States should also assure that linguistically and culturally appropriate outreach efforts are undertaken to all eligible populations. Another commenter recommended that HCFA require that applications be made available in the prevailing language in the community and that translation services be provided.

Response: As we seek to enroll all eligible children into coverage, States and HCFA should be sensitive to the cultural and linguistic differences of diverse populations. The diversity of the uninsured population requires outreach activities that are sensitive to the various cultural groups, their perceptions, needs and desires. For example, States could use outreach workers who live in the communities targeted for outreach, speak the language and know its cultural beliefs and practices. As noted in § 457.130, States must comply with all applicable civil rights requirements, including those related to language access. Within DHHS, the Office for Civil Rights (OCR) is responsible for assuring that DHHS-

funded programs comply with these laws. States are encouraged to contact OCR for additional guidance and technical assistance about how to comply with these laws.

Comment: Another commenter believed that outreach efforts should utilize Hispanic community-based organizations to ensure culturally and linguistically competent approaches to outreach. This commenter believed that specific outreach and education material be developed for the Hispanic community. Eligibility workers stationed in communities with a large Hispanic population should be able to speak the language spoken by potential applicants. The use of television (Spanish language) and other media sources should be used to target the Hispanic community. Another commenter suggested that HCFA amend § 457.90(b) to add examples of using ethnic media for education and awareness campaigns.

Response: Again, we encourage outreach activities that rely on workers who live in the communities being targeted for outreach, speak the relevant languages and know their cultural beliefs and practices. While we will not amend the text of § 457.90(b) to add examples of using ethnic media for education and awareness campaigns, we recognize that this can be an effective means of reaching ethnic communities. States are encouraged to implement outreach initiatives that are specifically designed to reach different targeted subpopulations such as the Hispanic community and other ethnic groups.

Comment: One commenter urged HCFA to amend § 457.90(a) to require State plans to include a description of outreach strategies to reach children and families with special needs including limited English proficiency populations, and families whose children have disabilities. This commenter also urged HCFA to include in § 457.90(b) examples of outreach strategies targeted to special populations.

Response: As noted in previous responses, States must implement outreach strategies that comply with all civil rights requirements. A State is required to describe its outreach strategies in the State plan, but we do not believe that States should be required to describe their strategies to target all special audiences, in part because State outreach activities are often changing in response to information about what does and does not work. The examples presented in the regulation are not meant to be exhaustive. As noted in a response above, it is impracticable to list in regulation all examples of effective outreach strategies.

Comment: One commenter suggested the final regulation include encouragement of State partnerships with HRSA grantees. This commenter believed that HRSA's access points in the field can and should be accountable for assisting States in making SCHIP outreach a success.

Response: We encourage States to partner with HRSA grantees to identify potentially eligible children, inform families of the availability of SCHIP and other public health coverage programs and provide application assistance.

Comment: Several commenters recommended that HCFA require States to describe in their SCHIP plans the efforts that they have made to consult with ''stakeholders'' regarding the outreach strategies that are likely to prove most effective. Suggested stakeholders include enrollees, providers, local officials, appropriate state agencies, WIC clinics, early childhood programs, schools, consumer groups, and homeless assistance programs. Another commenter recommended the use of stronger language than that used in the preamble to ensure public and potential enrollee participation in the creation of outreach materials and strategies. The commenter suggested replacing the word ''should'' with ''must'' in the following sentence: ''To be effective, messages and promotional materials must be developed with the assistance of people toward whom the message is directed.'' Another commenter recommended that HCFA require States to describe how they will identify populations of uninsured children and how they will enlist the assistance of members of these populations in developing procedures specifically designed to reach these populations and enroll them.

Response: States are required in § 457.120 to describe the methods the State uses to involve the public in both the design and implementation of the program and to ensure ongoing public involvement once the State plan has been implemented. We encourage States to consult with a wide variety of interested parties, including those listed by the commenters, in the development of outreach materials and strategies and recognize that such consultation, in many cases, is a mechanism for identifying the most effective outreach strategies. However, we have not revised the regulation text to specify that States describe in the State plan their efforts at consultation in regard to developing effective outreach strategies beyond the general requirements for public input already addressed in § 457.120. While States should develop materials with the assistance of people toward whom the message is directed, we do not believe that requiring States to consult with specific interested parties would ensure meaningful public involvement and provide States with continued flexibility regarding how best to involve targeted audiences in the development of outreach materials. A further discussion of public involvement is found in § 457.120.

Comment: Several commenters believed that the proposed requirements for State outreach programs were excessive because SCHIP is not an entitlement program, there is an express cap on administrative expenditures, and some States may elect not to fund SCHIP programs at a level to justify extensive outreach.

Another commenter asserted that the proposed regulation is overly prescriptive regarding the organizations that should be involved in outreach, the materials that should be produced, and the cultural variations that should be represented.

Response: We disagree that the requirements set forth in the proposed rule were too prescriptive. Section 2102(c) of the Act requires that a State plan include a description of its procedures to inform families of the availability of health coverage programs and to assist families in enrolling their children into a health coverage program. Therefore, families must be provided certain information to ensure that they are aware of available child health assistance. In addition, because of the importance of providing information that can be easily understood by the family, we have further specified information requirements in § 457.110 of this final rule. These basic rules for assuring that families are informed of the availability of coverage do not impose onerous burdens on States and in fact, are consistent with the activities States have already undertaken.

A key goal of this program is to ensure that families are informed about available coverage and are encouraged to participate. No single approach to reaching potentially eligible children is provided in the statute and thus, we are not requiring in § 457.90 that a State implement specific outreach activities. We also acknowledge that Federal funding for SCHIP is capped according to amounts specified by title XXI and States may design outreach programs with these caps in mind. States have the option to decide which methodologies and procedures it will use to inform families of potentially eligible children about the availability of SCHIP.

Comment: One commenter recommended that States be required to evaluate outreach efforts to determine which methods have been most effective (that is, collecting data from enrollment sites and polling enrollees about how they heard of the program.) This commenter also recommended that States should gather information from families who requested applications but did not complete them in order to determine their reasons for not submitting a completed application. States should use this information to choose the most effective and efficient outreach strategies.

Response: To conduct a successful outreach campaign, States should assess which outreach methods are most effective at enrolling eligible children into SCHIP. We will work with the States in a collaborative way to provide technical assistance and share successful strategies. However, we are not requiring a State to conduct a formal evaluation. In § 457.750, we do require States to report on strategic objectives in the annual reports. These objectives often address effectiveness of outreach.

Comment: Two commenters expressed concern about States involving the provider community in the program. One commenter suggested that the final rule encourage the participation of health care professionals through simplification of the provider enrollment process. Several commenters recommended that States be required to conduct outreach to the provider community about SCHIP and to provide information and training about the administrative/business procedures of the programs. This commenter noted that pediatricians and other providers must be informed about the new insurance programs as well as about Medicaid. One commenter noted that HCFA should require States to make administrative rules and procedures for SCHIP as simple and as similar to Medicaid as possible; coordinating these programs eases the administrative burden on physicians.

Response: We encourage States to partner with the provider community as part of their efforts to deliver health care services to Medicaid and SCHIP enrollees. Given that the provider level is the point at which enrollees access health care services, active provider participation and an understanding of the program is essential to the program's success. We strongly encourage States to work with provider groups in the State on an ongoing basis to facilitate provider participation in the program. If simplifying the provider application process is identified as needed in a State to increase access for SCHIP enrollees, then we would expect that a State would make every effort to address the issue.

A State and its providers should build a relationship based on the mutual goal of providing access to quality health care services. We encourage States to provide information about the administrative and business practices of SCHIP and Medicaid to providers' offices. We are promoting dual enrollment of providers.

Comment: One commenter noted that outreach should include providing information about the mental health and substance abuse, benefits in SCHIP plans, if provided.

Response: Neither the proposed not the final rules require States, as part of the outreach provision to provide information on benefits, including information on mental health and substance abuse benefits, to the general public. However, § 457.110(b)(1) requires that information on the types of benefits, and amount duration and scope of benefits available under the program must be made available to applicants and enrollees in a timely manner. This would include information of mental health and substance abuse benefits, if they are available under the State's approved benefit package.

Comment: One commenter recommended that HCFA require copies of client communication materials so that HCFA can evaluate the accuracy, effectiveness and perhaps establish a ''best practices'' culture for States in their partnership with HCFA in meeting their joint missions.

Response: We disagree with the commenter's recommendation that HCFA require copies of client communication materials, although we typically review such materials in our monitoring visits, we agree that direct communication material should be clear and consistent with the State plan rules and plan to work to provide technical assistance and facilitate the sharing of ''best practices.''

Comment: Several commenters urged HCFA to further discuss opportunities States have to outstation eligibility workers to help families enroll in separate child health programs. Several commenters suggested that HCFA include a full discussion of the advantages of using outstationed eligibility workers to enroll children in both Medicaid and SCHIP.

One commenter recommended that HCFA highlight that States are required under federal law to outstation workers at federally qualified health centers (FQHCs) and Disproportionate Share Hospitals (DSH) to conduct Medicaid eligibility determinations and one recommended that DSH hospitals and FQHCs are also ideal for outstationing sites in separate child health programs.

Other commenters believed that SCHIP plans should be subject to the Medicaid outstationing enrollment program requirements. One commenter noted that the requirement that States screen for Medicaid eligibility as part of the SCHIP application process makes it clear that State plans should be required to address how these requirements will be incorporated into the enrollment programs at FQHCs and DSH hospitals. Yet another commenter suggested that pediatricians' offices also serve as a prime location where families may receive help with the application process. Another commenter recommended that States consider outstationing eligibility workers at offices and clinics where uninsured families can be identified easily; and noted that monetary incentives can be offered to cover the cost of staff time associated with application assistance.

Response: We agree that outstationing eligibility workers is a promising outreach strategy for enrolling Medicaid and SCHIP-eligible children. ''Outstationing'' means locating eligibility workers or relying on other workers or volunteers, in locations other than welfare offices to assist with the initial processing of applications. (The final Medicaid eligibility determination must be made by the appropriate State agency.) States also can outstation eligibility workers in other locations and they can contract with community-based providers and organizations to assist with applications at other locations. Many locations, other than DSH hospitals and FQHCs, may be suitable for outstationing.

We disagree with the commenter's recommendation to include a full discussion of outstationing eligibility workers, and refer interested parties to the guidance issued on January 23, 1998, which provides the necessary detail. The Medicaid program already has specific regulations on this issue such as mandatory outstationing of workers at FQHCs and DSH hospitals, which can be found at 42 CFR 435.904. In separate child health programs, we encourage States to use outstationing, as it is one of many outreach strategies States have found to be valuable. Since Medicaid and SCHIP enrollment must be coordinated, Medicaid outstation sites provide a particularly important opportunity for enrolling children who are not eligible for Medicaid into SCHIP. In addition to Medicaid outstation sites, we recommend that States consider outstationing eligibility workers at other

sites that are frequented by families with children such as schools, child care centers, churches, Head Start centers, WIC offices, Job Corps sites, GED program, local Tribal organizations, Social Security offices, community health centers, disproportionate share hospitals and pediatricians' offices.

Comment: One commenter urged HCFA to adopt a requirement in the final rule that States include in the State plan an assessment of the extent to which procedural barriers may be discouraging enrollment or reenrollment of eligible children. For example, a survey of families once enrolled but failing to reenroll might indicate the need for longer enrollment periods, or the need for acceptance of self-declaration rather than actual verification of certain items like child care costs. This commenter suggested that the State plan could be a vehicle for a State to explain efforts made to examine these procedural barriers and indicate steps proposed to reduce them.

Response: We encourage States to assess and simplify their application and enrollment processes in an effort to reduce barriers to enrolling uninsured children. A burdensome application and enrollment process can be a significant barrier to successful enrollment. However, we are not requiring States to perform an assessment of procedural barriers in their State plan, although we encourage discussion of these issues in the annual report. Rather, we will work with States in a collaborative way to provide technical assistance and share successful procedures.

Comment: One commenter urged HCFA to encourage States to implement presumptive eligibility for both Medicaid and SCHIP.

Response: Information on presumptive eligibility is found in Subpart C and § 435.1101 and in our responses to comments on these provisions of the proposed regulation.

Comment: One commenter urged HCFA to reiterate to States the importance of assuring that they have properly implemented the delinking of TANF and Medicaid. The commenter noted that we will not be able to achieve the title XXI goal of covering more children, or of coordinating coverage among various health programs, if children continue to miss out on the health care coverage for which they are eligible as a result of inadequate implementation of delinking. This commenter requested that HCFA repeat the key elements of the discussion of ways to effectively implement delinking included in HHS' June 5, 1998, letter to Medicaid Directors and TANF Administrators and its March 22, 1999, Guide entitled Supporting Families in Transition. Furthermore, the commenter believed HCFA should stress that States must modify their computer systems to assure that families are not accountable for delinking, and assure that families do not lose Medicaid coverage inappropriately and to assure that families are informed about, and enrolled in, Transitional Medical Assistance whenever appropriate.

Response: Improving health care coverage through the delinking of Medicaid and TANF is a high priority in our efforts to reduce the number of uninsured children. Our guidance on this important initiative will be issued separately from this regulation.

Comment: Two commenters commended HCFA for the preamble discussion of ''enrollment simplification'' and HCFA's other efforts on this issue. However, this one commenter recommended that we clarify for States the parameters established by Federal law for taking steps to simplify application, enrollment, and redetermination procedures. This commenter recommended repeating the information provided in its September 10, 1998 letter to State officials regarding the minimum Federal requirements for the application and enrollment process for Medicaid and separate child health programs, with respect to simplification and opportunities to reduce verification requirements.

Response: The Federal requirements for the application and enrollment process for Medicaid and SCHIP provide a great deal of flexibility to States to design an application and enrollment process that is streamlined and simple, and avoids burdensome requirements for families that apply for benefits. As indicated in our September 10, 1998 letter to State officials, certain Federal rules apply to these processes. If a State chooses to develop a separate child health program, the only Federal requirements for the application and enrollment process are those listed in Subpart C for: (1) A screening and enrollment process designed by the State to ensure that Medicaid eligible children are identified and enrolled in Medicaid; and (2) obtaining proof of citizenship and verifying qualified alien status. The Federal requirements for an application and enrollment process in Medicaid are explained in 42 CFR 435.900. As many States' efforts to simplify application procedures demonstrate, States have broad flexibility under Federal law to simplify and streamline the enrollment procedures for both Medicaid and SCHIP.

Comment: One commenter urged HCFA to place greater emphasis on the ultimate goal of outreach—enrollment. In this commenter's view, the preamble language should be strengthened to encourage States to implement strategies for coordinating the enrollment processes of benefit programs such as WIC, Head Start, the School Lunch Program, subsidized child care and others with Medicaid and SCHIP enrollment. Efforts to enroll children in health coverage programs at the same time they enroll in other benefit programs should be encouraged.

Response: Thousands of low-income children are served by programs such as WIC, Head Start, the School Lunch Program, subsidized child care and the Child Support Enforcement program. We strongly encourage States to coordinate enrollment in other benefit programs that serve low-income children with Medicaid and SCHIP enrollment. For example, States may implement a referral system between the State's Medicaid agency, SCHIP agency (if different from the Medicaid agency) and other benefit program agencies. However, the coordination of these processes may only be applied to the extent that Medicaid and SCHIP rules allow. States must continue to meet the applicable Federal requirements for application and enrollment processes for Medicaid and SCHIP.

Comment: Two commenters recommended that HCFA state the rules relating to its child support enforcement policy under Medicaid and SCHIP. They request that HCFA should explicitly note the prohibition on denying Medicaid to children on the grounds that their parents have failed to cooperate with establishing paternity, or with medical support enforcement. They ask that HCFA highlight that States do not need to include questions about non-custodial parents on their joint or Medicaid applications, instead they can solicit such information at the time they notify families of their eligibility for coverage. HCFA should also reiterate that, regardless of when a State solicits such information, it must apprize families of the opportunity to show ''good cause'' for not providing the requested information.

Response: The rules for eligibility for SCHIP and our responses to comments on the proposed rules in this area, are found in Subpart C. Eligibility rules for Medicaid are issued under title XIX authority and are not discussed in this regulation.

Comment: One commenter suggested the use of licensed professional

insurance agents and brokers to enroll children. Insurance agents and brokers meet with uninsured adults every day, as well as the employers of many of the parents of uninsured children. Health insurance agents and brokers have a perfect opportunity to reach those that need the coverage the most, and since private health insurance plans already include a marketing component in their administrative cost, involving agents and brokers can be done with no extra cost to the program.

Response: As noted in § 457.340, States that implement separate child health programs may contract with independent entities to administer part or all of the eligibility determination process. A further discussion on the rules, and our responses to comments on the proposed rules pertaining to application processing is in Subpart C.

Comment: One commenter indicated that HCFA should include a description of the opportunity that States have to use innovative quality control projects to assure that allowing families to self-declare income does not increase the rate at which ineligible families get enrolled in coverage.

Response: Our requirements related to program integrity and responses to comments in this area are discussed in Subpart I.

12. Enrollment Assistance and Information Requirements (§ 457.110)

Section 2102(c) of the Act requires that State plans include procedures to inform families of the availability of child health assistance. In accordance with this provision, we proposed to require that a State have procedures to ensure that targeted low-income children are given information and assistance needed to access program benefits. Specifically, we proposed in § 457.110, that the State must make accurate, easily understood information available to families of targeted low-income children and provide assistance to them in making informed health care decisions about their health plans, professionals, and facilities. In order to assist families of targeted low-income children in making informed decisions about their health care, we proposed in § 457.110(b) to require that States have a mechanism in place to ensure that the type of benefits and amount, duration and scope of benefits available under SCHIP and the names and locations of current participating providers are made available to applicants and beneficiaries in a timely manner. This requirement also is consistent with the ''right to information'' provision of the President's Consumer Bill of Rights and Responsibilities and with the requirement in Section 2101(a) of the Act that child health assistance be provided in an effective and efficient manner.

We noted that the requirements set forth in this section apply to all States that are providing child health assistance, whether through a Medicaid expansion, a separate child health program, or a combination program, and whether they use fee-for-service or managed care delivery systems. Because Medicaid rules apply to States that implement Medicaid expansion programs, a State that is operating a Medicaid expansion program that uses managed care delivery systems would also be required to comply with the requirements of section 1932(a)(5) of the Social Security Act, enacted by section 4701(a)(5) of the BBA.

We proposed to require that information be easily understood and noted in the preamble that materials should be made available to applicants and beneficiaries in easily understood language and format. We noted in the preamble that the State should consider the special needs of those who, for example, are visually impaired or have limited reading proficiency, and the language barriers that may be faced by those who may use the information.

Comment: Several commenters expressed concern that the proposed rule did not expressly require States to provide information in a linguistically appropriate format, and one commenter recommended that HCFA add a requirement for linguistically appropriate information to the regulation. Several commenters stressed that HCFA should specify in the preamble that applicable title VI requirements related to linguistic accessibility to health care services and that HCFA requires States to communicate with enrollees in a language that they can understand.

One commenter recommended that HCFA provide examples of how States and contracted entities can comply with title VI requirements. Several commenters stated that HCFA should require States to take into account language in creating information materials. One commenter expressed concern about examples given in the preamble for overcoming language barriers. This commenter notes that two suggested methods should be used together as a part of a comprehensive plan to ensure linguistic access to services, but neither strategy alone would suffice to insulate the State from challenge under title VI.

Other commenters stated that HCFA should require States to provide translated oral and written notices including signage at key points of contact, informing potential applicants in their own language of their right to receive interpreter services free of charge. They further stated that bilingual enrollment workers and linguistically appropriate materials are necessary to ensure that limited English proficiency families make informed health care decisions. Another commenter feels that it is essential for HCFA to address the research-established higher risk for minority children to lack access to health insurance and health care in implementing SCHIP. This commenter noted that 14% of Americans speak a language other than English pursuant to Title VI of the Civil Rights Act. This commenter noted that HCFA has a responsibility to ensure that limited English proficient persons have a meaningful opportunity to participate in public programs.

Another commenter indicated that HCFA must elaborate on requirements to provide materials in alternative formats noted in the preamble and ensure that the rule includes an explicit reference to alternative formats. This commenter suggests that HCFA require materials be provided in accessible formats for persons with disabilities (e.g. tape recordings, large print, braille, etc.) and in appropriate reading levels for persons with limited literacy skills.

Response: After considering the commenters' concerns, we have taken the commenters' recommendation to add a linguistically appropriate requirement to the regulation. Section § 457.110 has been revised to require that the State must make accurate, easily understood, linguistically appropriate, information available to families of potential applicants, applicants, and enrollees, and provide assistance to these families in making informed health care decisions about their health plans, professionals, and facilities. In order to provide easily understood and linguistically appropriate information, States must assure meaningful communication for people who have limited English proficiency or have disabilities that impede their ability to communicate. This means that the State must assure that oral interpretation, sign language interpretation and auxiliary aids are provided to such potential applicants, applicants or enrollees. In addition, when necessary to ensure meaningful access, written information must be translated or made available in alternative formats such as large print or braille. ''For guidance in this area and for suggestions on how States can best meet title VI requirements, States should consult the DHHS Office for

Civil Rights' (OCR) ''Policy Guidance on the Title VI Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency,'' (the LEP guidance) at 65 FR 52762 (August 30, 2000). The guidance is also available on OCR's web site at *www.hhs.gov/ocr.*

Comment: Two commenters urged HCFA to mandate language access policies by establishing numeric or proportional thresholds according to which States must provide translations of all written materials and by adopting minimum standards and procedures that must be met when those thresholds are crossed by a SCHIP program. One of these commenters asserted that it is important to require a numeric threshold rather than a proportion threshold as population densities vary greatly. Providing flexibility to States is important; however, flexibility should be granted in strategies to provide linguistically and culturally competent services, not in determining whether there is a need for these services in a particular state or service area, according to this commenter. This commenter recommended that States be required in their State plan to describe how they will target families who speak threshold languages and how linguistic services will be provided to ensure access to application and enrollment assistance.

Response: States must comply with all civil rights requirements, including those related to language access. Because States must already comply with all civil rights requirements, we are not specifying thresholds for translation of material. The Office for Civil Rights (OCR) has responsibility for and issues policy on these matters. States and other interested parties may contact OCR for information relating to compliance with title VI requirements.

Comment: Two commenters proposed that HCFA require States to describe in their plans the procedures they will use to identify population needs for specialized information techniques, and how they will develop effective informing procedures for persons whose primary language is not English or who have physical or mental disabilities which require special information techniques. The commenter felt that this is necessary in order for States to be in compliance (as required in proposed rule § 457.130) with title VI of the Civil Rights Act and with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973.

Response: As discussed in previous responses, States are obligated to comply with civil rights requirements, including those related to language access. Because States must already comply with civil rights requirements as reflected in § 457.130, we are not further specifying procedures for identifying populations needing specialized information in this regulation.

Comment: One commenter recommended that HCFA prohibit States and contracted entities from requiring, suggesting, or encouraging beneficiaries to use family members or friends as translators except in cases of last resort. The commenter also recommended that the Department should prohibit the use of minors as translators in all instances.

Response: As noted above, the Office for Civil Rights recently issued guidance on the issue of translation services on August 30, 2000. The OCR guidance states that an enrollee/covered entity may not require an LEP person to use friends, minor children, or family members as interpreters. States and other interested parties may contact OCR for additional guidance on language access.

Comment: One commenter recommended that ''right to information'' principles for targeted low-income children be required for potential applicants as well. Information should be provided in an understandable format and in a language appropriate for the potential applicants as well as for the enrollees.

Response: We agree that it is important that potential applicants, as well as applicants and enrollees, have information about the program made available to them. Therefore, we have revised § 457.110(c) to require that, States must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants, and enrollees. States are encouraged to make information widely available, so that families have the opportunity to become familiar with the program.

Comment: One commenter supported the requirements in § 457.110 and the flexibility provided by suggestions in the preamble. This commenter believes that the proposed regulation fairly states the minimum information States must provide to prospective enrollees and enrollees. In this commenter's view, some of the preamble suggestions for additional information States might wish to provide are problematic and HCFA appropriately did not include these suggestions as requirements in the proposed rule. The commenter appreciates that the States are given the authority to determine how and when to provide materials in other languages and translation services.

Response: We note the commenter's support, but also need to make clear that States' discretion in this area is subject to the requirements of title VI.

Comment: One commenter recommended that HCFA add, in section 457.110(b)(1), cost sharing and other information that States must make available in order for families to make informed health care decisions.

One commenter suggested that HCFA include in the preamble a description of the types of more specific information that should be provided, such as access to information that assists health care consumers in making informed decisions and encourages accountability on the part of the health plans and providers. In this commenter's view, to alleviate concerns about overly burdensome requirements on States, additional categories of information could be made available to the public upon request.

Response: We have revised § 457.110(b) to require that certain information be made available to potential applicants, applicants, and enrollees. In addition to information on benefits and providers, § 457.110(b) requires that a State have a mechanism in place to make available information related to cost sharing, enrollment procedures, physician incentive plans, and review processes. We have added § 457.110(b)(2) to specify that cost-sharing requirements be made available. We have added § 457.110(b)(4) to require States to make available the circumstances under which enrollment caps or waiting lists may be instituted, including the process for deciding which children will be given priority for enrollment and how they will be informed of their status on a waiting list. We have also added § 457.110(b)(5) to require States to make available information on physician incentive plans described in § 422.210(b) of this chapter, as required by § 457.985 of this final rule. Finally, we have added § 457.110(b)(6) to require States to make available information on the process for review that is available to applicants and enrollees as described in § 457.1120. The information listed above is necessary to enable potential applicants, applicants and enrollees to make informed health care decisions.

In addition to the information that a State must make available, other basic information should be made available to families upon request. This information could include procedures for obtaining services, including authorization requirements; the extent to which after-hours and emergency services are provided; the rights and responsibilities of enrollees; any appeal rights that the

State chooses to make available to providers; with respect to managed care organizations and health care facilities, their licensure, certification, and accreditation status; and, with respect to health professionals, information that includes, but is not limited to, education and board certification and recertification. A State that provides services through a managed care delivery system should consider making additional information, such as the policy on referrals for specialty care and for other services not furnished by the enrollee's primary care physician, available to families of targeted low-income children.

Comment: Two commenters recommended that HCFA delete § 457.110. These commenters feel that States should have complete flexibility in the use of administrative dollars because they are capped by title XXI. According to this commenter, development of rules in this area is inappropriate and reduces State flexibility to design its program in the way that best serves the needs of that State's children. They note that States should be permitted to make these decisions and allowed to adopt commercial sector practices or practices more consistent with Medicaid.

Several commenters recommended that no specific requirements with respect to the information provided to families be adopted and that the level of assistance provided be determined by the State. These commenters indicated their belief that the proposed regulation is far too stringent and prescriptive regarding the level of enrollment assistance States are required to offer families. They noted that, in the commercial sector, health plans are not required to provide enrollment assistance to individuals. The commenters appreciated the authority provided to States to determine how and when to provide materials in other languages and translation materials and observed that States realize the importance of providing this information to families. However, the commenters noted that States are limited to a 10 percent expenditure allotment for enrollment, outreach and administration and that requiring additional material would be onerous.

Response: We disagree that the requirements set forth in § 457.110 are too prescriptive. Section 2102(c) of the Act requires that State plans include procedures to inform families of the availability of child health assistance under a State's program and to assist them in enrolling in such a program. We have provided sufficient flexibility to allow a State to design strategies that best meet the needs of families while setting minimum requirements consistent with these statutory provisions for the information that must be provided to assist families of targeted low-income children in making informed decisions about their health care.

We recognize that States have limited federal SCHIP matching funds available for administrative expenses. However, certain information must be provided to families to ensure that they are informed of the availability of child health assistance. We note that most private sector health plans routinely make available the information we have specified in this regulation to potential applicants and enrollees, including benefit descriptions and lists of participating providers. Moreover, a key goal of this program is to ensure that families are informed about available coverage and are encouraged to participate.

Comment: One commenter noted that the outreach and enrollment requirements are extensive considering the 10 percent cap and recommends modifying the rule to address the needs of applicants by requiring general information, or deleting the reference to applicants.

Response: We disagree that making this information available to applicants is not feasible due to the 10% cap on administrative spending. We are not requiring that the State provide each potential applicant with the required information, but to make the information available to potential applicants, and provide the information to applicants and enrollees in a timely manner. Potential applicants and applicants should have the opportunity to become familiar with the State's program so that they can make informed decisions about the program and selecting a health plan or provider. In the event that a potential applicant or an applicant becomes an enrollee, the child's family will already be informed about the services that are covered and how to access those services. This is particularly important if the child has immediate medical needs.

Comment: According to one commenter, providing current provider participation information is an impractical requirement. States should be free to update provider participation information on a periodic basis. Other commenters stated that it is difficult to distribute hard copy information of up-to-date provider lists to all enrollees; however, they suggest that web sites and toll-free numbers be listed as suggested methods of making up-to-date information available.

Response: States are required to have a mechanism to ensure that the names and locations of current participating providers are made available to applicants and enrollees. States may update directories on a periodic basis as long as there is another mechanism through which enrollees can obtain current information. For example, a State could use a telephone hotline to make current information available to applicants and enrollees.

Comment: One commenter recommended that the State should be required to distribute information that lists the enrollee's benefits and an updated provider directory listing available providers as soon as a child enrolls in SCHIP. According to this commenter, States should be required to consistently update a database for the provider directory since providers will change often and materials should be available in all languages enrollees speak.

Response: Under § 457.110(b), States must make information available to potential applicants, applicants and enrollees in a timely manner. States should provide this information, which includes benefit and provider information, within a reasonable amount of time after an individual is enrolled in SCHIP if the information is not provided before enrollment. Information should be provided to enrollees so that they have sufficient time to choose a primary care provider and a health plan where there is a choice. As indicated in the previous response, States must have a mechanism to ensure that current provider information is available. Furthermore, States are required by § 457.110(a) to make information available to families of potential applicants, applicants and enrollees in an easily understood, linguistically appropriate format. States must also meet more general civil rights requirements as specified under § 457.130.

Comment: One commenter encouraged States to make enrollment assistance available in providers' offices and indicated that enrollment assistance should also be provided in child care settings. All families applying for child care assistance should receive information about SCHIP and Medicaid according to this commenter.

Response: We encourage States to make information about enrollment procedures available to health care providers. States that implement separate child health programs are required under § 457.370 of this final regulation to provide application assistance and health care provider offices are often a logical place to

provide such assistance. Further information on this requirement is found in § 457.361 and in our responses to comments on that section. We also encourage States to make SCHIP outreach material available to families applying for or receiving child care assistance. Child care agencies often serve the same children who States are trying to reach through their child health outreach strategies. As noted in § 457.90, no single approach to reaching children is prescribed in this regulation and multiple approaches are likely to be most effective.

Comment: One commenter supported the requirement that States make accurate, easily understood information relevant to enrollment available to families of potentially eligible children. The commenter urged HCFA to make clear that such information should be available to adolescents, as well as their families. In this commenter's view, provider information should indicate providers specializing in, or with an interest in, adolescent care.

Response: As defined in § 457.10, a child is an individual under the age of 19. Hence, the term ''child'' includes adolescents within that age range. We encourage States to consider ways to reach out directly to adolescents, such as by providing age appropriate outreach and education materials directly to adolescents since they may obtain health care services independently of their parents or family members. Furthermore, adolescents should be provided information that assists them in identifying and linking up with providers that specialize in adolescent health care. This information should be freely available to anyone who requests it.

Comment: One commenter recommended that HCFA require States to inform and educate parents of children with special health needs about special services available for their children and how to access these services.

Response: We encourage States to consider the unique needs of families with children with special health needs when developing procedures to provide information to families. If applicable, States should provide information regarding supplemental benefits for special needs populations. Further discussion on assuring appropriate treatment for enrollees with chronic, complex or serious medical conditions is found in § 457.495(b) and in our response to comments on that section.

Comment: A commenter suggested that HCFA emphasize that States take special steps to target educational material to families of newborns to ensure enrollment during the crucial first months of life when screenings, vaccinations, and preventive care visits are vital.

Response: We encourage States to take additional steps, beyond making the information required at § 457.110(b) available, to educate special audiences. Families of newborns will benefit from educational programs designed to inform them of the advantages of enrolling eligible newborns in health insurance, including obtaining well-baby care and immunizations. As required in § 457.495, a State plan must include a description of the States' methods for assuring the quality and appropriateness of care, particularly with respect to providing well-baby/well-child care and childhood immunizations, as well as other areas highlighted by that section. A further discussion of State plan requirements relating to appropriateness of care is contained in § 457.735 and our responses to comments on that section.

Comment: Several commenters expressed concern that the proposed rules do not provide clear, detailed standards under § 457.110. These commenters expressed that it would be appropriate for HCFA to provide more detailed regulatory requirements as to what is meant by the timely provision of information, criteria for easily understood information, and direction as to format. They recommend that States should list providers by corporate name and popular name, by individual provider names, and by the entity (such as health center).

Response: States should have the flexibility to design a mechanism for providing information that will best meet the needs of potential applicants, applicants and enrollees, including whether there is a need to refer to providers by more than one name and their entity. In the spirit of State flexibility, we do not agree with the suggestion to further define timely provision of information, criteria for easily understood information, or direction as to format—aside from what has already been define in applicable Federal law. No one approach is most effective in providing information in all settings and to all audiences; therefore, we are not adopting this suggestion.

Comment: One commenter noted that the family needs to understand the consequences of applying for a separate child health program and being found eligible for Medicaid.

Response: The requirements for providing this information to applicants are found in subpart C, including § 457.360(a), relating to informed application decisions.

Comment: One commenter strongly supported the requirement that States provide specific benefit and provider information in an easily understood format and language. This commenter recommended that the list of other basic information, as stated in the supplementary information, include consent and confidentiality laws for minors and be included in the final language of § 457.110(b). Another commenter noted that the section regarding the integration of the Consumer Bill of Rights should include protections for families as parental consent will generally be a requisite for treatment under SCHIP.

Response: We note the commenter's support for the requirement to provide information in an easily understood format and language. However, we disagree with the recommendation of requiring a State to provide information on consent and confidentiality laws for minors. While we agree that this may be a good idea, we believe that requiring that such information be provided would be an undue burden on States, and therefore we have not amended the regulation text to require that States provide this information to applicants or enrollees. However, we note that in § 457.1110(b)(4), we require States to assure that all contractors protect the confidentiality of information about minors and the privacy of minors in accordance with applicable Federal and State law.

Comment: One commenter felt that consumer participation in treatment should be ''developmentally appropriate.'' The commenter recommended that HCFA add language about appropriate participation of guardians and parents and the family in general.

Response: We encourage States and providers to communicate in terms that can be understood by consumers with varied developmental levels. Further information on assuring quality and appropriateness of care is found in § 457.495 and the responses to comments on that section.

Comment: One commenter requested clarification of HCFA's intent and expectations in requiring States to assist families in making health care decisions. Several other commenters requested clarification that assisting families does not include decisions relating to the direct provision of care, and that these decisions should be made between parents and the health care provider.

Response: States should have the flexibility to design a mechanism to assist families in making informed health care decisions about their health

plans, professionals, and facilities that best meets the needs of the families in the State. No one approach may be the most effective in assisting families. Section § 457.110(a) requires that the State provide assistance to families in making informed health care decisions about their health plans, professionals, and facilities. All decisions regarding treatment options should be made between the patient, the family (as appropriate), and the health care provider. In order to assist families in making health care decisions, States must, at a minimum, have a mechanism in place to ensure that information is provided as required by § 457.110(b).

13. Public Involvement in Program Development (§ 457.120)

States are required under section 2107(c) of the Act to include in the State plan the process that the State used to accomplish public involvement in the design and implementation of the plan and the method to ensure ongoing public involvement. We proposed to implement this provision at § 457.120.

In the preamble to the proposed rule we encourage States to provide for participation from organizations and groups such as hospitals, community health centers, and other providers, enrollees, and advocacy groups. We also suggested mechanisms for encouraging public involvement such as through holding public meetings, establishing a child health commission, publishing notices in newspapers, or creating other methods for public access to materials. We indicated that States may use any process for public input that affords interested parties the opportunity to learn about the State plan and allow for public input in all phases of the program.

Comment: Several commenters strongly encouraged public participation in all aspects of planning, implementation, evaluation and monitoring of SCHIP. These commenters, including several States, specifically cited the value of participation from individuals, families, Native Americans, organizations concerned with the health of adolescents, and other stakeholders. They noted the ability of public participants to assist federal State and local officials in identifying the characteristics and needs of enrollees, suggesting effective program designs and implementation techniques, and gathering and reporting information on enrollees' experiences with SCHIP. These commenters therefore supported the proposed requirements that State plans describe the procedures to be used to involve the public in the design and implementation of the program and ensure ongoing public involvement, and also supported the public notice requirement for State plan amendments. They also supported the ideas and suggestions contained in the preamble to the proposed rule. Some commenters suggested strengthening the regulatory provisions by requiring States to engage in specific activities and collect public participation data to ensure that State programs are effectively involving the public.

Response: We agree that public involvement is integral to the success of SCHIP in every State and appreciate the support of the commenters. We have included the requirement at § 457.120 for initial and ongoing public involvement, consistent with the statute, in order to ensure that it takes place. Our early experience with SCHIP as well as our experience with other programs demonstrate the benefit of public participation in identifying and resolving issues.

We encourage States to take a thoughtful approach to ensuring ongoing public involvement once the State plan has been implemented. We believe that the most effective approach to ensuring public input is to allow States the flexibility to design a process that affords interested parties the opportunity to learn about, and comment on, proposed changes in the program and to identify problems and make suggestions for improvement to the administering agency. States should employ multiple methods of obtaining public input and provide for participation by a wide variety of stakeholders. To encourage public involvement, a State can—

- Hold periodic public hearings to provide a forum for comments when developing or implementing their State plans and plan amendments;
- Establish a child health commission or a consumer advisory committee that is responsible for soliciting broader public opinion about the State plan and formulating the development of program changes, and have their meetings open to members of the public;
- Make presentations to, and solicit input from, child health, consumer advisory or medical care advisory groups and provider groups;
- Publish notices in generally circulated newspapers advertising State plan or amendment development meetings so the public can provide input;
- Create a mechanism enabling the public to receive copies of working proposals, such as proposed State plan amendments, and provide ''stakeholders'' with the opportunity to submit comments to the State (such as mailing information to ''stakeholders,'' including providers and families likely to be served by SCHIP or posting information about proposed changes on a State web site);
- Use a process specified by the State legislature prior to submission of the proposal;
- Provide for formal notice of, and comment on, program changes in accordance with the State's administrative procedure act; and/or
- Any other similar process for public input that would afford an interested party the opportunity to learn about and comment on proposed changes in the program and to offer comments on how the program is operating and suggestions for improvements.

In addition, all State plans, amendments, annual reports and evaluations are made available to the public on the HCFA web site to ensure ongoing public participation. States have flexibility in the manner in which they choose to involve the public in learning about and commenting on program design and implementation. While we will monitor States' activities and effectiveness related to public involvement, we do not accept the suggestion to require collection of public participation data in this final rule.

Comment: One commenter appreciated the prompt posting of State plan information, approval and disapproval letters, amendment fact sheets, and summary information on the HCFA web site.

Response: We appreciate the commenter's support for the information posted on HCFA's web site.

Comment: Several commenters requested that HCFA further discuss the inclusion of various stakeholder groups into the public process. Some urged HCFA to discuss in the preamble ways to include parents of SCHIP children in the planning and monitoring of benefits and service deliver systems. Others suggested expanding the provisions of the rule to specify types of groups that should be involved, including parents, children, teachers, advocates, providers of services to low-income and uninsured children, agencies involved in the provision of medical and related services, managed care entities that hold SCHIP contracts, and the mental health and substance abuse communities. Some commenters also recommended including involvement by physicians' organizations and dentists. One commenter suggested ensuring that public participants should have experience in caring for, and knowledge about, adolescents. Several of the

commenters also recommended that the rule specify the aspects of the plan that should be subject to public input, and should include eligibility, benefits, program design, provider qualifications and payment, outreach and enrollment procedures, and family cost sharing.

Response: We encourage States to involve all ''stakeholders'' throughout the development and operation of the program. ''Stakeholders'' may include parents, children, teachers, advocates, the mental health and substance abuse community, dental providers, physicians and physicians' organizations, managed care entities, and other groups with experience in caring for and knowledge of children, including adolescents. We do not agree that the regulation should specify groups that must be involved nor those program elements for which public involvement is required, because appropriate involvement may vary based upon the program element under consideration and circumstances within a specific State. States may ensure public involvement through a variety of approaches, as noted above. As part of its ongoing method for ensuring public involvement, States are encouraged to consult with stakeholders in the development of annual reports and evaluations. As indicated in previous responses, each State must make a concerted effort to involve the public on an ongoing basis but should have the flexibility to design the processes for involving the public in light of the circumstances in each State.

Comment: One commenter and its member organizations urge strengthened and more detailed requirements for public input at the State level. One commenter strongly recommended more guidance to the States about required public participation in the development and implementation of their plans, including substantial changes to the plans. Although this commenter's State policy makers have kept a coalition of stakeholders (including consumer organizations and health care providers) informed about many changes and have solicited the coalition's input on a regular basis, they noted in their view that numerous major program decisions that could have a significant impact on consumers have been made without public input. This commenter noted that the State SCHIP legislation requires the State agency to adopt rules, which requires a formal notice and hearing process, but stated that the agency has not yet promulgated a single rule. Another commenter urged that HCFA require specific methods for soliciting and obtaining public input, even if States are permitted to select from among alternate specified methods. Some commenters urged HCFA to specifically enforce public input requirements, and to ensure that the public involvement is meaningful.

Response: We do not agree that mandating a particular set of procedures would necessarily ensure meaningful public involvement. Methods that work effectively in one State may not work or be utilized effectively in another State. It is vitally important that a State employ carefully considered methods to ensure involvement of a wide variety of interested parties. This variation across States necessitates allowing a State the flexibility to tailor its methods to the population it serves and other State characteristics. We encourage States to employ multiple methods of obtaining public input. We monitor compliance with all State plan and regulatory requirements, including those related to public involvement.

Comment: A commenter noted that, in the preamble to the proposed rule, HCFA encouraged States to create a mechanism enabling the public to receive copies of working proposals in order to provide comments to the States and that most States have posted their original State plans on the web or have made ordering information available to the public. But this commenter stated that States have not extended this same courtesy with proposed amendments of State plans. States are often unwilling to share proposed amendments and changes in the program until the amendment has been approved by HCFA. This practice inhibits public involvement in the development of the program in this commenter's view. This commenter urged that HCFA design procedures that enforce the requirement that States ensure ongoing public involvement in the amendment process.

Response: We encourage States to provide working copies of State plan amendments to interested parties so they may provide valuable input into the design of program changes. However, we are not requiring States to do so. States must have a method to ensure ongoing public involvement beyond the initial implementation of the program and we will monitor compliance with all requirements, including those related to ongoing public involvement. We would like to be informed if interested parties do not believe they have adequate means to provide input into the SCHIP design and implementation.

Comment: One commenter strongly encouraged HCFA to provide further elaboration in the rule itself on strategies that States should use to promote public involvement. Specifically, the commenter recommended that the final rule should require States to offer the public several different avenues for providing substantial input into the design and ongoing implementation of SCHIP, including public involvement in ''substantial'' State plan amendments. For example, the commenter noted that the final rule could specify that States can satisfy the requirement to involve the public in SCHIP by undertaking a number of the following activities: convening public hearings; advertising public hearings in generally circulated newspapers; making presentations to child health, consumer advisory or medical care advisory groups; mailing information about program implementation to stakeholders, including providers and families likely to be served by SCHIP; and posting information about the status of SCHIP implementation on a State web site. In this commenter's view, it is essential that the final rule do more than list possible examples of how States could comply with the public input requirement, and, in particular, not suggest that undertaking one of a long list of strategies will be sufficient.

Response: We encourage States to use multiple methods of obtaining public input. In a previous response in this section, we have provided further suggestions promoting public involvement and a number of these suggestions reflect this commenter's suggestions. However, as noted and explained previously, we have not revised the regulation to require or include specific methods for ensuring public involvement.

Comment: One commenter applauded HCFA's efforts to increase access to information and believes that requirements for State and local level input as the programs are developed and amended, including specification of a variety of clearly defined methods of providing input, can only help SCHIP.

Response: As indicated in previous responses in this section, we encourage States to take a thoughtful approach in developing methods to ensure public involvement, however, specifying methods in regulation is not necessarily the most effective way of ensuring public involvement within each State.

Comment: One commenter set forth the view that the methods described in the preamble for ensuring public involvement are excellent if used and publicized. This commenter recommended that States be required to report the methods used annually so that advocates and family members can understand the mechanisms for participation. In the view of this

commenter, small public notices are not a meaningful way to reach consumers and this commenter is using the web postings by HCFA to help educate parent leaders. This commenter encouraged families to go to the web site to find their States' annual report to help them understand the program and become involved in the SCHIP process. If the annual report contains no reference to public input, there is no opportunity for participation by consumers and the rules regarding public involvement are rendered useless, in this commenter's view.

Response: We appreciate the commenter's support of our suggested methods for public involvement. However, we disagree that the rules for public involvement are useless unless we require a description of the State's methods in the annual report. States are required to include in the State plan a description of the method the State uses to ensure ongoing public involvement and we will monitor compliance with this State plan requirement as we would monitor compliance with other Federal requirements. To reach a wide variety of stakeholders, we encourage States to use multiple methods of seeking input.

14. Provision of Child Health Assistance to American Indian and Alaska Native (AI/AN) Children (§ 457.125)

To implement section 2102(b)(3)(D) of the Act, we proposed to require a State in § 457.125(a) to include in its State plan a description of procedures used to ensure the provision of child health assistance to American Indian or Alaska Native children. We also requested in § 457.125(a) that the State officials responsible for SCHIP consult with Federally recognized Tribes and other Indian Tribes and organizations in the State on the development and implementation of the procedures used to ensure the provision of child health assistance to American Indian or Alaska Native children. Although not specified in the regulation, we had indicated in the preamble that such groups could include regional Indian health boards, urban Indian health organizations, non-Federally recognized Tribes, and units of the Indian Health Service.

We proposed in § 457.125(b) that we will not approve a State plan that imposes cost sharing on AI/AN children. In the preamble, we stated our view that the imposition of cost sharing on children in AI/AN families may adversely impact the State's ability to ensure coverage for this group as required under section 2102(b)(3)(D) of the Act. This provision applies to States that operate either a separate child health program or a Medicaid expansion program, including Medicaid expansion programs under a section 1115 demonstration project.

Please note that all comments and responses relating to the policy of prohibiting cost sharing for AI/AN children are addressed in the summary for Subpart E.

Comment: One commenting State agreed with the provision at § 457.125 that requires procedures to ensure that tribal children are offered SCHIP, and requests that States consult with federally recognized and other tribes. One commenter recommended that HCFA should strengthen § 457.125 by *requiring* State officials responsible for SCHIP to consult with federally recognized tribes and other Indian tribes and organizations in their States on the development and implementation of child health assistance to American Indian and Alaska Native children.

One commenter added that communication with various AI/AN groups (including IHS, tribal representatives, and urban Indian groups and organizations) is an effective way to accomplish the goal of enrolling AI/AN children in SCHIP. However, this commenter noted that the States should only be required to consult with Federally recognized Tribes. This commenter also noted that Federally recognized tribes should be the ones who ask that IHS or Indian organizations participate in coalitions or meetings to avoid confusion about who represents those tribes. In this commenter's view, federal agencies can enhance tribal/State relations by supporting tribal/State meetings and by providing technical assistance.

Response: We have taken these comments into consideration and agree with the recommendation to require interaction with Indian Tribes. We have moved and revised the provision at § 457.125(a) requesting that a State consult with Federally recognized Tribes and other Indian tribes and organizations in the State on the development and implementation of the procedures to ensure the provision of child health assistance to American Indian and Alaska Native (AI/AN) children. Section 2102(b)(3)(D) of the Act requires a State to include in its plan a description of procedures used to ensure the provision of child health assistance to AI/AN children. A State cannot meet the requirement for ensuring the provision of child health assistance to AI/AN children without interaction with Tribes. Additionally, Section 2102(b)(3)(D) of the Act requires that child health assistance is provided to Indians. We have, therefore, revised the language at § 457.120(c) to require interaction with ''Indian Tribes and organizations in the State'' as opposed to limiting the interaction to Federally recognized Tribes. The final language at § 457.120(c), given these revisions, requires that a State plan include a description of the method the State uses to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in § 457.125(a) to ensure the provision of child health assistance to AI/AN children.

Given our broader definition of those Tribes that must be interacted with, we do not believe it is necessary to further interpret the definition of a ''Federally recognized Tribe'' or who should attend meetings. States are required to involve a range of other ''stakeholders'' pursuant to § 457.120 (a) and (b), as described earlier. We do support Tribal/State meetings related to SCHIP and are willing to provide technical assistance as needed in this area.

Comment: Multiple commenters expressed that States have a genuine interest in consulting with tribes and their related organizations to ensure that all children receive available health coverage, but caution against dual State and federal consultations that may result in confusion.

Response: The required interaction between States and Indian Tribes and other organizations in the State does not replace the federal government's consultation. The Federal government continues to be required to consult with Federally recognized Tribes. We have revised the language of the regulation to specify ''interaction'' to make clear that State actions do not replace the Federal consultation role.

Comment: One commenter urged that HCFA make federal matching funds available at the 100 percent rate for expenditures under separate child health programs for services to AI/AN children received through IHS facilities, the same rate available for such expenditures under Medicaid. According to this commenter, the inequitable treatment of separate child health programs will negatively affect the ability of such programs to serve more SCHIP-eligible children.

Response: Unlike Medicaid, title XXI does not provide the authority for Federal financial participation (FFP) at a level higher than the enhanced title XXI FMAP for any service including those provided at IHS or tribally-administered facilities. A statutory change by Congress would be required in order to permit 100 percent FFP for SCHIP services provided through IHS and tribal facilities.

15. Civil Rights Assurance (§ 457.130)

In § 457.130, we proposed to require the State plan to include an assurance that the State will comply with all applicable civil rights requirements. This assurance is necessary for all programs involving continuing Federal financial assistance in accordance with 45 CFR 80.4 and 84.5. These civil rights requirements include title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84 and part 91, and 28 CFR part 35.

Comment: One commenter noted that this section correctly reminds States that they are required to comply with civil rights laws. However, the commenter noted that this section of the regulation and the preamble should explain that States will violate civil rights laws if they fail to provide linguistically appropriate and accessible services. The commenter recommended that the final regulation should provide more information on each of the listed civil rights statutes and should include examples of violations and compliance. Many other commenters made similar recommendations.

Response: Because primary authority within the Department of Health and Human Services for enforcement of civil rights requirements is held by the Office for Civil Rights, interested parties should contact the Office for Civil Rights directly for more information on compliance with these requirements. States are required by civil rights law to provide linguistically appropriate and linguistically accessible services, as described in the response to the following comment.

Comment: Several commenters noted their view that it is very important for HCFA to articulate clearly the States' obligations under current law (Title VI, 45 CFR Part 80) to provide linguistic access. Three commenters specifically recommended that HCFA, at a minimum, should incorporate in this regulation the standards for providing linguistic and cultural access to services set forth in a 1998 Guidance Memorandum issued by OCR. These commenters also suggested that even stronger standards than those provided by the Guidance Memorandum are often necessary and recommended that HCFA mandate aggressive language access policies by establishing numeric or proportional thresholds, and then mandate minimum standards and procedures that must be adopted when those thresholds are met. They recommended that HCFA also should give consideration to ensuring the cultural and linguistic competency of a SCHIP program. They noted that, for example, it cannot be assumed that because a worker is bilingual, he or she is sufficiently familiar with medical terms and concepts in both languages to provide competent translation services.

Several commenters recommended that the Department should also prohibit States and participating contractors from requiring, suggesting, or encouraging beneficiaries to use family members or friends as interpreters (which should only be done as a last resort), and absolutely prohibit the use of minors as interpreters, regardless of the enrollee's willingness. In the view of these commenters, there also should be explicit instructions to provide clear, translated signage and written materials informing applicants and clients of their right to receive bilingual or interpreter services. A different commenter agreed with the above recommendation and emphasized that access to SCHIP-covered services needs to be provided regardless of the number of individuals from a given language group who live in a given service area and regardless of how obscure the language is. Another commenter also suggested that the States and the Department analyze gaps in data needed for establishing the above described thresholds, and that States and the Department should consider encouraging providers to have paid, trained interpreters or bilingual providers on staff because face-to-face interpretive services are more effective.

Yet another commenter also suggested the adoption of minimum standards for the provision of SCHIP services to persons with limited English proficiency (LEP). This commenter suggested that these minimum standards should include: written policies and procedures on the development, dissemination and use of medical interpreter services; cultural competency standards and training; notice of the right to a free interpreter at all points of contact; prohibition on the use of minors as interpreters and the use of family and friends as a last resort for interpretation and only after being given notice of the right to a free interpreter.

Other commenters suggested that HCFA give examples of how States and contracted entities can comply with title VI, such as providing bilingual workers selected through formal criteria for translation vendors, and linguistically appropriate materials that include accommodations (such as oral, audio, or video formats) for limited English proficiency speakers who do not read well in their primary language or whose languages lack a written version.

Response: A State's obligation to provide linguistically appropriate communication and services flows from a federal fund recipient's obligation to ensure equal access under title VI. Further discussion of language access is found in the responses to comments on § 457.110(a).

Comment: One commenter is concerned that the section does not address the civil rights duties of contractors. Many States contract and sub-contract with entities to administer their programs. This commenter recommended that § 457.130 explain that contracted entities are also required to comply with civil rights laws. In addition, the commenter felt the following sections, and the discussions of each in the preamble, should emphasize that the Department requires contracting entities to comply with civil rights protections: § 457.940 (procurement standards); § 457.945 (certification for contracts and proposals), § 457.950 (contract and payment requirements including certification of payment information). Other commenters agreed with the recommendation that this section should address the civil rights duties of contractors and that the other sections in Subpart I should be amended similarly as well.

Response: A State's contractors, subcontractors and grantees are required to comply with all civil rights laws. When the State contracts with other entities, the State must ensure that its contractors comply with all applicable laws. Because § 457.130 already requires a State to provide an assurance that the State will comply with all applicable civil rights laws, we do not agree that Subpart I should be amended. Section 457.130 already places an obligation on a State to assure that it performs SCHIP-related activities in accordance with applicable federal laws.

Comment: A couple of commenters requested that HCFA amend many other sections to ''incorporate enrollment assistance.'' Specifically, the commenters recommended requiring that States:

- Provide bilingual outreach workers, linguistically appropriate materials, and culturally appropriate strategies when needed (§ 457.90);
- Provide translated oral and written notices, including signage at key points of contact informing potential applicants in their own language of their right to receive interpreter services free of charge (§ 457.110);
- Include the use of bilingual workers, translators, and linguistically

appropriate materials for limited English proficiency populations as required under title VI, in application assistance (§ 457.361(a));

• Take reasonable steps to convey information about notices of rights and responsibilities and decisions concerning eligibility in a culturally and linguistically appropriate manner to ensure that all applicants, including those who are limited English proficiency, are given notice of, and understand, their rights, responsibilities, and decisions concerning their eligibility (§ 457.361(b), (c));

• Provide bilingual workers and linguistically appropriate materials regarding grievances and appeals when needed (§ 457.365);

• Provide notice to beneficiaries about their rights to linguistic access to services (§ 457.995).

Other commenters urged that cultural competency and linguistic accessibility requirements be incorporated throughout the provisions on information, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and nondiscrimination, and grievances and appeals.

Response: A State must comply with civil rights requirements in the operation of all elements of its program. We do not agree that other sections of the regulation, as suggested by the commenter, should be amended since a State must provide an assurance pursuant to § 457.130 that the State plan will be conducted in compliance with all civil rights requirements.

Comment: One commenter noted that, without explanation, HCFA dropped sexual orientation, genetic information, and source of payment as part of the civil rights assurance in its effort to integrate the Consumer Bill of Rights. This commenter requested that HCFA include the source of payment in the final regulation, as it is a major source of discrimination in access to dental services.

Response: The assurance of compliance with civil rights law seeks to assure that the State and its contractors comply with applicable civil rights laws and regulations, without specifying particular policies, procedures, or actions that would constitute a violation of those laws. Generally, to the extent that actions of the State or its contractors based on sexual orientation, genetic information or source of payment discriminate against individuals based on race, ethnicity, color, sex, age or disability, those actions most likely would constitute a violation of the civil rights laws and regulations. States and organizations should contact the Office for Civil Rights (OCR) for more information regarding specific prohibited actions under the civil rights laws and regulations enforced by OCR.

Comment: One commenter asked whether States will be able to sign the civil rights assurance if HCFA implements § 457.125 regarding cost sharing for AI/AN children.

Response: As further discussed in § 457.535, the exemption of AI/AN families from cost sharing is consistent with title VI of the Civil Rights Act of 1964. Therefore, the implementation of § 457.125 will not affect a State's ability to provide an assurance that it will comply with applicable civil rights requirements.

16. Assurance of Compliance With Other Provisions (§ 457.135)

In accordance with section 2107(e) of the Act, we proposed in § 457.135 to require that the State plan include an assurance that the State will comply under title XXI with the following provisions of titles XIX and XI of the Social Security Act:

• Section 1902(a)(4)(C) (relating to conflict of interest standards).

• Paragraphs (2), (16) and (17) of section 1903(i) (relating to limitations on payment).

• Section 1903(w) (relating to limitations on provider donations and taxes).

• Section 1132 (relating to periods within which claims must be filed).

Section 2107(e)(2)(A) of the Act also provides that section 1115 of Act, pertaining to research and demonstration waivers, applies to title XXI. This provision grants the Secretary the same section 1115 waiver authority in title XXI programs as in title XIX programs. In the preamble to the proposed rule, we discussed in detail the extent to which waivers of both title XIX and title XXI provisions should be granted under SCHIP. Specifically, we stated that while the law permits the Secretary to use section 1115 authority to waive provisions of title XXI in order to pursue research and demonstration projects, we do not believe it would be reasonable to grant waivers under section 1115 before States have experience in operating their new title XXI programs and can effectively design and monitor the results of demonstration proposals. We stated that we would consider a section 1115 demonstration proposal for waiver of title XXI provisions only after a State has had at least one year of SCHIP experience and has conducted an evaluation of that experience. We invited comments on the best approach to considering section 1115 waivers of title XXI provisions.

We noted that because both the Federal government and the States have substantial experience in administering title XIX, we believed that we were in a position to consider and grant waivers of title XIX provisions even when the demonstration project involves the SCHIP-related enhanced match. We stated that we would consider a request for section 1115 waivers of title XIX provisions applicable to Medicaid expansion programs without any additional experience with the program.

We only received comments in this section related to our statements in the preamble regarding consideration of section 1115 demonstrations. Therefore, we are implementing the above described regulatory provisions as set forth in the proposed rule. We will be considering those comments as we develop our policies on section 1115 demonstration projects under title XXI.

17. Budget (§ 457.140)

Section 2107(d) of the Act specifies that a State plan must include a description of the budget, updated periodically as necessary, including details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost sharing by enrollees. We proposed in § 457.140 that the State plan must include a budget that describes both planned use of funds and sources of the non-Federal share of plan expenditures (including any requirements for cost sharing by beneficiaries) for a 3-year period. We also proposed to require that an amended budget included in a State plan amendment include the required description for a 3-year period. We proposed that the planned use of funds include the projected amount to be spent on health services, the projected amount to be spent on administrative costs, and assumptions on which the budget is based.

Please note that additional comments on budget, particularly related to State plan amendments, are addressed in the comments and responses to § 457.60.

Comment: One commenter believed that budget issues did not necessarily tie well with the submittal of plan amendments. For example, a State may go several years without submitting a plan amendment. Several commenters suggested that budget data would best be gathered through the annual reporting process through which States are required to update budget estimates on a yearly basis.

Another commenter stated that the submission of a three-year budget, to the extent that it requires specific budget items, has the potential for being burdensome. This commenter, along with another, expressed that a two-year budget estimate should be sufficient for federal planning purposes. One State indicated that it operates on an annual budgetary cycle and that all budgets are developed by the legislature and approved by the Executive branch annually, so the State does not have any legal authority to develop three-year budget projections.

Response: We agree with the first commenters' suggestion and have reconsidered the requirement at proposed § 457.140 that the State plan, or plan amendment as required at § 457.60(b), must include a budget that describes the State's planned expenditures for a three-year period. We have revised § 457.140 to require that the State plan or plan amendment include a budget that describes the State's planned expenditures for a one-year period. Furthermore, because we are requiring that the budget be updated periodically through the annual report and through quarterly financial reporting, we have revised the requirement at proposed § 457.60(b), (now § 457.60(d)) to require a one-year budget only with State plan amendments that have a significant budgetary impact. Examples of these types of amendments would be those that related to eligibility, as required by § 457.60(b)(1), or cost sharing as required by § 457.60(b)(6) or benefits as required by § 457.60(b)(4). For example, if the amendment added or dropped a package of dental benefits that would have an impact on expenditures, the State would need to submit an amended budget with the amendment. The description of the budget must be submitted in accordance with § 457.60(d) and must continue to meet the requirements of § 457.140(a) and (b). The changes to these provisions will relieve States from having to provide budget descriptions with all State plan amendments. At the same time, we will continue to require a description of planned expenditures for a three-year period each year through the annual report from every State with an approved State plan.

Because States have up to three years to spend each annual allotment, a three-year budget is useful to show if States are planning to use their unused allotments in the succeeding two fiscal years and if they, therefore, anticipate a short fall in Federal funding. We realize that a State must base the required information on projections and that the budget projections submitted to HCFA are not approved by a State's legislature. However, it is important to have this information to ensure the State has adequately planned for its program and to analyze spending of the allotments.

18. HCFA Review of State Plan Material (§ 457.150)

Section 2106 of the Act provides the Secretary of DHHS with the authority to approve and disapprove State plans and plan amendments. The authority vested in the Secretary under title XXI has been delegated to the Administrator of HCFA with the limitation that no State plan or plan amendment will be disapproved without consultation and discussion by the Administrator with the Secretary. We also described this delegation of authority at proposed § 457.150(c).

Under the authority of section 2106 of the Act, we proposed at § 457.150(a) to specify that HCFA reviews, approves and disapproves all State plans and plan amendments. We noted in the preamble to the proposed regulation that the Center for Medicaid and State Operations within HCFA has the primary responsibility for administering the Federal aspects of title XXI. We also noted therein that we would continue to work jointly with the Health Resources and Services Administration (HRSA) to implement and monitor the new program as a part of the Department's overall strategy to support coordination with other Federal and State health programs in providing outreach to uninsured children and promoting coordination of care and other public health interventions. Consistent with the Department's strategy, the current State plan and plan amendment review process involves collaboration with other agencies within the Department and Administration as well. The approval or disapproval of all State plans or amendments presently requires consensus among all of the participating Department components.

Section 2106 does not speak of partial approval or disapproval of a State plan or plan amendment. Thus, at § 457.150(b) we proposed that HCFA approves or disapproves the State plan or plan amendment only in its entirety. We noted in preamble to the proposed regulation that as appropriate and feasible, States may withdraw portions of a pending State plan or plan amendment that may lead to delay in its approval or disapproval. In § 457.150(d), we proposed that the HCFA Administrator designate an official to receive the initial submission of a State plan. In § 457.150(e), we proposed that the HCFA Administrator designate an individual to coordinate HCFA's review for each State that submits a State plan.

Comment: Many commenters questioned the necessity of approving or disapproving a State plan or amendment only in its entirety as provided under proposed § 457.150(b). In the opinion of these commenters, this provision may detrimentally affect what States submit. In these commenters' view, even though a State may have an innovative idea that has come out of the development and public consultation process, it may be reluctant to ''push the envelope'' with the idea for fear that it may hold up a larger state plan or plan amendment. If only a single provision is preventing approval, it would be more effective to approve the rest of the submission and then work with the State on the questionable provision. One of these commenters noted their view that this requirement limits the State flexibility that Congress envisioned in passing title XXI.

A different commenter believed this provision to be administratively burdensome because it encourages States to submit each component of an amendment separately rather than one complete document that provides a more comprehensive picture of the program. This commenter also requested that HCFA approve sections of a plan amendment and allow the State to implement the changes while other sections are under review. Yet another commenter also indicated their belief that the approval process should have more flexibility. If a State plan or plan amendment can be implemented without inclusion of that part, this commenter believes that the entire plan or plan amendment should not be held up for that one small part. Another State concurred with this view. One more commenter says that the provision may be an impediment to, or cause delay in, making innovative changes to a State's program. In this commenter's view, States will be forced to prepare amendments in a piecemeal fashion, causing more work and a greater administrative burden. It would be more efficient for States to be allowed to submit comprehensive program changes that HCFA can approve or deny in part according to this commenter.

Response: HCFA approves or disapproves the State plan or plan amendment only in its entirety because section 2106 does not permit the Secretary to partially approve or disapprove a State plan or plan amendment. Additionally, it would be administratively burdensome for HCFA to track and monitor only portions of approved State plans or plan amendments. However, States may

withdraw or change portions of a proposed State plan or plan amendment at any time during the review process. States need not submit components of a State plan amendment separately, because States may withdraw portions of a pending State plan amendment that may lead to delay in its approval or disapproval of the amendment. Additionally, States have the option to split a single State plan amendment into separate amendments during the review process. Given these options, we do not agree that this provision necessarily limits State flexibility or increases administrative burden and we will work with States to prevent this from occurring.

Comment: Several commenters asserted that the regulations should not provide for review of whether previously approved State plan material complies with title XXI requirements, unless federal law or regulations change. These commenters read section 2106 to mean that, once a State plan provision has been approved, the provision cannot be revoked unless the statute is amended. These commenters specifically argued that new regulations or guidance documents do not provide a basis for revoking approval of a State plan provision. And these commenters assert that disturbing previously approved State plan provisions could disrupt the stability of programs and continuity of care for children. Some commenters, while generally agreeing, indicated that, at a minimum, States should have a reasonable time to come into compliance.

Response: We disagree that the scope of HCFA's authority to determine whether previously approved material continues to meet the requirements for approval should be restricted to changes in statutory or regulatory requirements. Sections 2101(b) and 2101(a)(1) require State plans to be consistent with the requirements of title XXI. Accordingly, we base approval or disapproval of State plan and plan amendments on relevant Federal statutes, including title XXI and title XIX, regulations, and guidelines issued by HCFA to aid in the interpretation of the statutes and regulations. Regulations and guidelines are issued by HCFA in order to implement relevant statutes.

States may continue to rely on approval of a State plan or plan amendment and the receipt of federal matching funds associated with such approval. States will be given an opportunity to correct any parts of the State plan that no longer meet the conditions for approval. Compliance actions will not be imposed without the opportunity for correction afforded by section 2106(d)(2) of the Act and subpart B of part 457 implementing that section of the Act.

19. Notice and Timing of HCFA Action on State Plan Material (§ 457.160)

Section 2106(c) sets forth requirements relating to notice and timing of State plan material. In § 457.160(a), we proposed that the HCFA Administrator will send written notification of the approval or disapproval of a State plan or plan amendment. While section 2106(c)(2) only requires that written notification be sent for disapproval and requests for additional information, we proposed to require that written notification be sent for approvals as well.

In § 457.160(b)(2), we proposed that the State plan or plan amendment be considered received on the day the designated official or individual, as designated pursuant to § 457.150(d) and (e), receives an electronic, fax or hard copy of the complete plan or plan amendment. The complete plan includes any referenced documentation, such as attachments, benefits plans or actuarial analyses.

As required by section 2106(c)(2), a State plan or plan amendment will be considered approved unless HCFA, within 90 days after receipt of the State plan or plan amendment, sends the State written notice of disapproval or written notice of any additional information it needs in order to make a final determination. The Act does not specify calendar days or business days. We proposed to measure the 90-day review period using calendar days. The 90-day review period would not expire until 12:00 a.m. eastern time on the 91st countable calendar day after receipt (except that the 90-day period cannot stop or end on a non-business day), as calculated using the rules set forth in the proposed regulation and discussed below.

Section 2106(c) sets forth requirements relating to notice and timing of action on State plan material. In § 457.160(b)(3), we proposed that if HCFA provides written notice requesting additional information, the 90-day review period is stopped on the day HCFA sends the written request for additional information. This written request will be considered sent on the day that the letter is signed and dated except if that day is a weekend or Federal holiday, in which case the review period will stop on the next business day. We proposed that the review period will resume on the next calendar day after the complete additional information is received by the designated individual, unless the State's response is received after 5:00 p.m. eastern time on a day prior to a non-business day or any time on a non-business day, in which case the review period will resume on the following business day. We proposed in § 457.160(b)(4) that the 90-day review period cannot stop or end on a non-business day. HCFA will not stop a review period on a weekend or holiday. If the 90th day of a review period is scheduled to be on a weekend or holiday, then the 90th day will be the following business day. Additionally, in § 457.160(b)(5), we proposed that HCFA may send written notice of its need for additional information (and therefore, stop the 90-day review period) as many times as necessary to obtain the necessary information for making a final decision whether to approve the State plan or plan amendment.

Comment: One commenter supported HCFA's proposal to send written notification of State plan approvals even though the statute requires only written notification of disapprovals.

Response: We note the commenter's support.

Comment: One commenter agreed with HCFA's use of 90 calendar days. One commenter proposed that some allowance should be made for expedited approval of State plan amendments because SCHIP programs are such a high priority for the States and the federal government. This commenter expressed the opinion that allowing for more than 90 days each time federal approval is needed, even for simple changes, is a deterrent to quick, innovative program adjustments. They recommended that HCFA should strive for expeditious responses to State plan amendments and, whenever possible, should take action in fewer than 90 days.

Response: We appreciate the support of the first commenter. As for the expedited approval of State plan amendments, section 2106(c)(2) of the Act provides that a State plan or plan amendment will be considered approved unless HCFA, within 90 days after receipt of the State plan or plan amendment, sends the State written notice of disapproval or written notice of any additional information it needs in order to make a final determination. We make every attempt to expedite responses to State plan amendments and recognize their importance to the States and the Federal government. The 90-day time frame is the outer time limit for action; it does not preclude action in a shorter time period and we will strive to take quicker action whenever possible.

Comment: One commenter proposed that the State plan or amendment be

considered received by HCFA the day it is delivered to the HCFA office rather than the day it is received by a specified individual. In this commenter's view, the State should not be penalized for delays in HCFA's internal delivery system. In this State's case, two weeks after the amendment was delivered to the HCFA Central Office, the Regional Office reported to the State that the amendment had not been received by the Central Office. The State was able to obtain a signed cartage statement indicating that it had been delivered to the office and thereby protected the submission date.

Response: We disagree with the commenter's suggestion that a State plan or plan amendment be considered received by HCFA on the day is it delivered to HCFA. As set forth in § 457.160(b)(2), a State plan or plan amendment is considered received on the day the designated individual or official receives an electronic, fax or paper copy of the complete material. This is intended to simplify administration of the program. At this point in the program, each State has received correspondence notifying it of the identity of the designated individual. If the designated individual is unavailable during regular business hours, another HCFA employee will act in place of the designated individual to ensure that the review period is counted as if the designated individual was in the office. However, in cases where States send an amendment to an individual or address other than the one designated, HCFA cannot begin the review until the amendment is received by the designated individual.

Comment: One commenter disagreed with this provision that provides that if HCFA requests additional information, the 90 day review period stops but resumes on the next calendar day after HCFA receives all of the requested information. The commenter recommended that HCFA adopt the approach used in Medicaid under 42 CFR 430.16(a)(2) which states that if HCFA requests additional information, the 90 day review period for HCFA action on the plan or plan amendment begins on the day it receives that information. The commenter reasoned that under proposed § 457.150(b), ''HCFA approves or disapproves the State plan or plan amendment only in its entirety''. Yet under proposed § 457.160(b)(3), if HCFA has determined that additional information is needed, HCFA will have fewer than 90 days to review that information once it is submitted. Although this commenter indicated that it understands the strong interest in moving quickly to implement SCHIP, the commenter saw no reason to accelerate a review process when the initial State submission was inadequate or incomplete. The commenter felt that using the current Medicaid standard would promote consistency and ensure that HCFA has sufficient time for review.

Response: We are committed to expeditious review of State plans and plan amendments. The process set forth in § 457.160(b)(3), that the 90 day review period resumes on the next calendar day after HCFA receives all requested information, will help ensure an expeditious review. We are not using the review period policies in effect under Medicaid, as the Medicaid statute differs from title XXI in this regard and we believe the speedier and more flexible process described in § 457.160(b)(3) will more effectively implement title XXI objectives. To allow us the maximum review time within the review period, we have set forth rules that the review period be started (or restarted) on the first full day following receipt of the plan (or additional information) and the review period will resume on the following business day if the response is received after 5 p.m. eastern time on a day prior to a non-business day or any time on a non-business day.

Comment: One commenter requested that HCFA make every effort to request all necessary information initially so that multiple stoppages of the 90 day clock are less likely to occur. Another commenter wrote that HCFA should not have unlimited ability to stop the clock.

Response: HCFA's formal request for information may include a description of specific issues that need clarification, an outline of additional information required, or a request for resolution of any inconsistencies of the plan with title XXI provisions. We will continue to make every effort to identify those issues for which we need additional information early in the review process. However, many times a State's response will trigger further questions. By allowing the review period to be stopped as many times as necessary to obtain the information needed to make a decision, States are provided ample opportunity to demonstrate compliance with the requirements of the program.

20. Withdrawal Process (§ 457.170)

In § 457.170, we proposed to allow a State to withdraw its State plan or State plan amendment at any time during the review process by providing written notice to HCFA of the withdrawal. This proposed process is consistent with the process for withdrawal of a proposed Medicaid State plan amendment.

Comment: A number of commenters suggested that a State be allowed to withdraw any portion of a proposed submitted plan (and not just a whole plan or amendment) in order to expedite the approval process when a limited number of its provisions are slowing down the plan review process.

Response: In our review of State plans and plan amendments, we have allowed and will continue to allow a State to withdraw a portion of its proposed State plan or proposed plan amendment. In order to clarify this provision, we have revised § 457.170(a) to require that a State may withdraw its proposed State plan or proposed plan amendment, or any portion of its State plan or plan amendment, at any time during the review process by providing written notice to HCFA of the withdrawal.

Comment: One commenter recommended that the State be required to provide public notice and a meaningful opportunity for public input prior to any withdrawal.

Response: We encourage States to involve the public in all phases of the program, including, to the extent feasible, prior to withdrawal of a proposed State plan amendment.

Comment: One commenter suggested that we clarify that a State may withdraw its approved State plan at any time if the State chooses to discontinue its program.

Response: A State may withdraw a proposed State plan or plan amendment by providing written notice to HCFA of the withdrawal in the form of a State plan amendment. We have added a provision at § 457.170(b) to clarify that a State may request withdrawal of an approved State plan by submitting a State plan amendment to HCFA as required by § 457.60. Because withdrawal of a State plan is a restriction on eligibility, a State plan amendment to request withdrawal of an approved State plan must be submitted in accordance with requirements set forth in § 457.65(b), including those related to the provision of prior public notice. Although HCFA does not have authority to deny such a State plan amendment request, this requirement conforms with the requirements of section 2106(b)(3) relating to State plan amendments that restrict eligibility. We note that withdrawal of a Medicaid expansion program may also require an amendment to the title XIX State plan.

21. Administrative and Judicial Review of Action on State Plan Material (§ 457.190)

Under Section 2107(e)(2)(B) of the Act, a State dissatisfied with the Administrator's action on State plan

material has a right to administrative review and judicial review. In § 457.190(a), we proposed a procedure for administrative review. Specifically, we proposed to require that any State dissatisfied with the Administrator's action on State plan material under § 457.150 may, within 60 days after receipt of the notice of final determination provided under § 457.160(a), request that the Administrator reconsider whether the State plan or plan amendment conforms with the requirements for approval. Additionally, we proposed that the procedures for hearings and judicial review be the same procedures used in Medicaid which are set forth in regulations at part 430, subpart D. We also proposed that HCFA will not delay the denial of Federal funds, if required by the Administrator's original determination, pending a hearing decision. If the Administrator determines that the original decision was incorrect, HCFA will pay the State a lump sum equal to any funds incorrectly denied.

Comment: One commenter supported the proposed procedure for administrative and judicial review.

Response: We note the support of the commenter.

C. Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

1. Basis, Scope, and Applicability (§ 457.300)

This subpart interprets and implements provisions of section 2102 of the Act which relate to eligibility standards and methodologies and to coordination with other public health insurance programs; section 2105(c)(6)(B), which precludes payment for expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and section 2110(b), which defines the term ''targeted low-income child.'' This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures. We proposed that the requirements of this subpart apply to a separate child health program and, with respect to the definition of targeted low-income child only, to a Medicaid expansion program.

As discussed in the response to the first comment below, we have removed from the proposed definition of ''optional targeted low income child'' for purposes of a Medicaid expansion the cross reference to § 457.310(a) in subpart C and have revised the definition of ''optional targeted low-income child'', which is now located at §§ 435.4 and 436.3 of this chapter. Comments regarding optional targeted low-income children for purposes of a Medicaid expansion program are addressed in the preamble to subpart M. Conforming changes have been made to the definition of ''targeted low-income child'' at § 457.310. This subpart now applies only to a separate child health program.

We received no comments on § 457.300 and, with the exception of the one change noted, are implementing it as proposed. General comments on subpart C are discussed in detail below.

Comment: We received two requests that the Medicaid regulations clarify the definition of ''optional targeted low-income child.'' The commenters are of the opinion that the cross-reference to the title XXI regulations is confusing. They note that some provisions in title XXI, such as permitting States to limit eligibility by geographic region, do not apply in Medicaid.

Response: We accept the commenters' request to clarify the definition of optional targeted low-income child in the Medicaid regulations, rather than cross-reference § 457.310(a). In proposed § 435.229(a), the cross-reference to § 457.310(a) incorporated provisions of the definition of targeted low-income child that only apply in a separate child health program. We have removed the cross-reference to § 457.310(a) and added a specific Medicaid definition of optional targeted low-income child in § 435.4 (and in § 436.3 for Guam, Puerto Rico, and the Virgin Islands).

Comment: We received a number of comments recognizing that certain policies were statutory and urging HCFA to seek statutory changes. The suggested changes included the following:

Allow a State the option to keep a pregnant teen enrolled in a separate child health program even if she becomes eligible for Medicaid as a pregnant woman.

Allow States to deem an infant eligible for a separate child health program for a full year if the birth is covered by a separate child health program.

Response: We will take these suggestions into consideration in developing future legislative proposals and appreciate the commenters' recognition that these issues are driven by the statute.

Comment: Several commenters were concerned about the interaction of various public programs. Two urged HCFA to reiterate the importance of ensuring the Medicaid eligibility is not tied to eligibility for Temporary Assistance for Needy Families (TANF) under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

Response: Under the welfare reform provisions of PRWORA, the link between Medicaid and cash assistance (previously given as Aid To Families with Dependent Children, or AFDC) was severed. This ''delinking'' of Medicaid from cash assistance assured Medicaid eligibility for low-income families regardless of whether the family is receiving welfare payments, and offers States new opportunities to provide a broader range of low-income families health care coverage. In an effort to help States better understand their opportunities and responsibilities under the law, DHHS, HCFA, and the Administration on Children and Families (ACF) have issued substantial guidance on how to implement the delinking provisions, including fact sheets, letters to State Medicaid and TANF Directors, updates to the State Medicaid Manual, and the publication of a 28-page, plain-English guide entitled, ''Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World.'' State Medicaid Director letters dated October 4, 1996, February 5, 1997, April 1, 1997, September 22, 1997, and August 17, 1998 dealt with the implementation of the section 1931 eligibility category; letters dated February 6, 1997 and April 22, 1997 discussed redetermination procedures; and eight additional letters covered immigration, outreach and enrollment, MEQC errors, and the availability of the $500 million delinkage fund. Last fall, at the direction of President Clinton, HCFA conducted comprehensive on-site visits in all States to review State TANF and Medicaid application and enrollment policies and procedures. HCFA is currently finishing the ensuing reports and working with the States to address problems that have been identified. An April 7, 2000 letter to State Medicaid Directors requires States to take steps to identify and reinstate individuals who have been terminated improperly from Medicaid and to ensure that their computer systems are not improperly denying or terminating persons from Medicaid. The letter also provides important guidance regarding redetermination. A series of Questions and Answers concerning this letter can be found under the heading ''Welfare Reform and Medicaid'' on HCFA's web

site at: *http://www.hcfa.gov/medicaid/medicaid.htm.*

Based on the findings of HCFA's reviews and the reviews that States are undertaking to comply with the April 7, 2000 guidance, HCFA is providing further guidance and technical assistance to States in the areas of application and notice simplification, outreach to eligible families, and modification of computer systems, among others. HCFA, in partnership with ACF, the Food and Nutrition Service, the American Public Human Services Association, and the National Governors Association, is also disseminating best practices so that States can assist one another as they move forward to correct problems and improve participation among eligible low-income families.

Comment: We received one comment urging HCFA to include information about presumptive eligibility under a separate child health program in the preamble to the SCHIP financial regulation. Another urged HCFA to encourage States to provide presumptive eligibility for children as this is particularly important to children experiencing a mental health crisis.

Response: States have the authority to implement a presumptive eligibility procedure under its separate child health program. This was implicit under title XXI as originally enacted and now, with the enactment of the Benefits Improvement and Protection Act of 2000(BIPA) (Pub. L. 106–554), the authority to implement presumptive eligibility procedures in separate child health programs is explicit.

Under section 803 of BIPA, States have the option to establish a presumptive eligibility procedure and, consistent with the flexibility now granted States under the Medicaid presumptive eligibility option (see section 708 of BIPA, amending section 1920A(b)(3)(A)(i) of title XIX), States have broad discretion to determine which entities shall determine presumptive eligibility, subject to the approval of the Secretary. For example, States can rely on health care providers, child care providers, WIC, or Head Start centers, or the contractors that may be doing the initial SCHIP/Medicaid eligibility screen.

Under the presumptive eligibility established under Medicaid and carried over to SCHIP under the BIPA legislation, a family has until the end of the month following the month in which the presumptive eligibility determination is made to submit an application for the separate child health program (or the presumptive eligibility application may serve as the application for the separate child health program, at State option). If an application is filed, the presumptive eligibility period continues until the State makes a determination of eligibility under the separate child health program (subject to the Medicaid screening requirements). In accordance with section 457.355, if a child enrolled in a separate child health program on a presumptive basis is later determined to have been eligible for the separate child health program, the costs for that child during the presumptive eligibility period will be considered expenditures for child health assistance for targeted low-income children and subject to the enhanced FMAP. If the child is found to have been Medicaid-eligible during the period of presumptive eligibility, the costs for the child during the presumptive eligibility period can be considered Medicaid program expenditures, subject to the appropriate Medicaid FMAP (the enhanced match rate or the regular match rate, depending on whether the child is a optional targeted low-income child).

We have revised the policy stated in the preamble of the proposed rule regarding children who are enrolled through presumptive eligibility, but who are later not found to be eligible under the separate child health program or Medicaid. In the proposed rule, we noted that the costs for coverage of such children during the presumptive period must be claimed as SCHIP administrative expenditures, subject to the enhanced match and the 10 percent cap. BIPA, however, authorizes presumptive eligibility under separate child health programs in accordance with section 1920A of the Act, and the statute now allows health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

Comment: One commenter thought that greater coordination among HCFA, the Office of Child Support Enforcement (OCSE), State child support agencies, and SCHIP stakeholders would increase the likelihood of children receiving the best available health care. The commenter noted that many children who qualify for SCHIP are members of single-parent families and could benefit from the services of the child support program. Conversely, SCHIP programs can ensure that children have access to quality health care when a noncustodial parent's employer does not offer health insurance, the health insurance is available only at a prohibitive cost, or it is not reasonably accessible to the child. Another commenter suggested that the preamble explicitly note the prohibition on denying Medicaid to children on the grounds that their parents have failed to cooperate with establishing paternity or with medical support enforcement and also highlight that States do not need to include questions about noncustodial parents on their joint applications, but rather can solicit such information at the time that they notify the family of eligibility.

Response: We agree that it is important that children benefit from the services of the child support program. HCFA has issued guidance to States under title XIX about the importance of informing families who receive Medicaid about available State Child Support Enforcement services. We have instructed State Medicaid agencies to coordinate with State CSE agencies to ensure that children who could benefit from these services receive them. We encourage States to inform families who apply for coverage under their separate child health programs about CSE services.

CSE agencies can also serve as a source of information about available health care coverage for families who seek CSE services. In many cases, families are not able to secure health care coverage through a child's absent parent. In such cases, CSE can help the family obtain coverage through SCHIP or Medicaid if the State promotes coordination between its CSE and child health coverage. Several States have reported taking such steps as part of their outreach and coordination activities.

While child support services can provide important support to many families, questions about absent parents on a child health application can be a barrier to enrollment. Under Medicaid, the recent guidance issued to State Medicaid agencies reiterates that cooperation of a parent with the establishment of paternity and pursuit of support cannot be made a condition of a child's eligibility for Medicaid. Moreover, the guidance informs States that they are not required to request information about an absent parent on a Medicaid application (or a joint Medicaid/separate child health program

application) that is only for a child and not for the parent.

Comment: One commenter felt that the eligibility screens and information requirements in the proposed regulations went beyond the statutory requirements, are excessively burdensome and will make it impossible to effectively coordinate with other programs, such as the school lunch program, Head Start, or WIC.

Response: We disagree with the commenter's assertion that the regulations have created barriers to enrollment in the SCHIP program. We have provided States with considerable flexibility with respect to how to meet the requirements of the statute, and have worked in this final rule to further expand that flexibility in many cases. The statute specifically requires that States screen all applicant children for Medicaid eligibility and enroll them in Medicaid if appropriate. To that end we have encouraged, and the majority of States have adopted, joint applications which significantly decrease the complexity of the application and enrollment process. We have permitted States flexibility with respect to the design of their applications and their application processes, although we encourage States to streamline the enrollment process in SCHIP and Medicaid (for example, elimination of assets tests, using mail-in applications, minimizing verification requirements) to enable families to access coverage under a separate child health program or Medicaid as quickly and easily as possible. We acknowledge the difficulties that exist in coordinating different public programs and have provided flexibility wherever possible; but that flexibility is constrained by the statutory provisions that are designed to ensure that children are enrolled in the appropriate program. States have taken advantage of the flexibility permitted to design varied and effective coordination procedures. We are committed to working closely with the States to help them implement procedures that work effectively for them and to share their ideas and experiences with other States.

2. Definitions and Use of Terms (§ 457.301)

This section includes the definitions and terms used in this subpart. Because of the unique Federal-State relationship that is the basis for this program and in keeping with our commitment to State flexibility, we determined that many terms should be left to the States to define. For purposes of this subpart, we proposed to define the terms ''employment with a public agency,'' ''public agency,'' and ''State health benefits plan.''

We proposed to define ''public agency'' to include a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity. We proposed to define the term ''employment with a public agency'' as employment with an entity under a contract with a public agency. The term was intended to include both direct and indirect employment because we did not wish to influence or restrict the organizational flexibility of State and local governmental units. We proposed to define the term ''State health benefits plan'' as a plan that is offered or organized by the State government on behalf of State employees or other public agency employees within the State.

Comment: Commenters objected to the definition of ''employment with a public agency'' as being too inclusive. They noted particular concern about the inclusion of ''entities contracting with a public agency'' in the definition. Commenters felt the inclusion of this group could unfairly deny coverage to children in families who are not State employees.

Response: We are deleting our proposed definition of ''employment with a public agency'' in § 457.301. In § 457.310(c)(1)(i), we will track the statutory language at section 2110 (b)(2)(B), which excludes from eligibility ''a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.'' State law will determine whether parents employed by contracting agencies are employed by a public agency and whether their children are eligible for health benefits coverage under a State health benefits plan. If the State determines that a child is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, then the child is ineligible for coverage under a separate child health program. In addition, we have revised the definition of ''State health benefits plan'' to clarify that we would not consider a benefit plan with no State contribution toward the cost of coverage and in which no State employees participate as a State health benefits plan.

3. State Plan Provisions (§ 457.305)

In accordance with the requirements of section 2102(b)(1)(A) of the Act, we proposed to require that the State plan include a description of the State's eligibility standards.

Comment: Several organizations commented that HCFA should require States that limit the number of children who can enroll in a separate child health program to describe their procedures for deciding which children will be given priority for enrollment and how States will ensure that equal access is provided to children with pre-existing conditions; their processes for discontinuing enrollment if program funds are depleted; how they will comply with the prohibition on enrolling children at higher income levels without covering children at lower income levels; how the waiting lists will be fairly administered. The commenters also suggested that we require these States to maintain sufficient records to document that favoritism or discrimination does not occur in selecting individuals for enrollment. Additionally, commenters suggested that § 457.305 or § 457.350, should specifically require that a Medicaid screen be conducted before a child is placed on a waiting list.

Response: States are required under § 457.305 to include as part of their State plan a description of their standards for determining eligibility. We are clarifying in regulation text that this must include a description of the processes, if any, for instituting enrollment caps, establishing waiting lists, deciding which children will be given priority for enrollment. This clarification of the regulation text conforms with actual HCFA practice. HCFA has requested States that have adopted enrollment caps to describe in their State plans their policies for establishing enrollment caps and waiting lists and for enrolling children from any waiting lists. We also have added a provision at § 457.350(h) requiring that applicants must be screened for Medicaid prior to being placed on a waiting list due to an enrollment cap. Not doing so would place Medicaid-eligible children on a waiting list and undermine a fundamental goal of the statute—to enroll children in health insurance programs for which they are eligible. In this case, arrangements must be made for the joint application to be processed promptly by the Medicaid program.

States must afford every individual the opportunity to apply for child health assistance without delay in accordance with § 457.340, and facilitate Medicaid enrollment, if applicable, in accordance with § 457.350, prior to placing a child on a waiting list for a separate child health program. We have amended the language of § 457.305 (relating to State

plan requirements) to reflect this requirement.

If, after a State plan is approved by HCFA, the State opts to restrict eligibility by discontinuing enrollment, by establishing an enrollment cap, or by instituting a waiting list, the State must submit a State plan amendment requesting approval for the eligibility changes as required by § 457.60(a). Because we believe these changes in enrollment procedures constitute restrictions of eligibility, the amendment must be submitted in accordance with the requirements at § 457.65(d). With respect to public input, HCFA also requires in § 457.120 that States ensure ongoing public involvement once the State plan has been submitted.

4. Targeted Low-Income Child (§ 457.310)

In accordance with § 2110(b) of the Act, we proposed to define a targeted low-income child as a child who meets the eligibility requirements established in the State plan pursuant to § 457.320 as well as certain other statutory conditions specified in this section. At § 457.310(b), we set forth proposed standards for targeted low-income children that relate to financial need and eligibility for other health coverage, including coverage under a State health benefits plan. In addition, we set forth exclusions from the category of targeted low-income children.

With regard to financial need, we proposed that a child who resides in a State with a Medicaid applicable income level, must have: (1) family income at or below 200 percent of the Federal poverty line; or (2) family income that either exceeds the Medicaid applicable income level (but by not more than 50 percentage points) or does not exceed the Medicaid applicable income level determined as of June 1, 1997. We left States the discretion to define ''income'' and ''family'' for purposes of determining financial need.

We note that we have modified § 457.310(b)(1) to clarify the definition of targeted low-income child. We made technical corrections, in accordance with section 2110(b) to indicate that a targeted low-income child may reside in a State that does not have a Medicaid applicable income level and that a targeted low-income child may have a family income at or below 200 percent of the Federal poverty line for a family of the size involved, whether or not the State has a Medicaid applicable income level. In addition, we have revised proposed § 457.310(b)(1)(iii), now § 457.310(b)(1)(iii)(B), for purposes of clarity. A targeted low-income child who resides in a State that has a Medicaid applicable income level, may have income that does not exceed the income level that has been specified under the policies of the State plan under title XIX on June 1, 1997. This provision effectively allows children who became eligible for Medicaid as a result of an expansion of Medicaid that was effective between March 31 and June 1, 1997 to be considered targeted low-income children. It also means that children who were below the Medicaid applicable income level but were not Medicaid eligible due to financial reasons that were not related to income (e.g. due to an assets test) can be covered by SCHIP.

With regard to other coverage, we proposed that a targeted low-income child must not be found eligible for Medicaid (determined either through the Medicaid application process or the screening process discussed later in this preamble); or covered under a group health plan or under health insurance coverage, unless the health insurance coverage has been in operation since before July 1, 1997, and is administered by a State that receives no Federal funds for the program's operation. However, we proposed that we would not consider a child to be covered under a group health plan if the child did not have reasonable access to care under that plan.

With regard to exclusions, we proposed at § 457.310(c)(1) that a targeted low-income child may not be a member of a family eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency so long as more than a nominal contribution to the cost of the health benefit plan is available from the State or public agency with respect to the child. We proposed to set the nominal contribution at $10.

Section 2110(b)(2)(A) of the Act excludes from the definition of targeted low-income child a child who is an inmate of a public institution or who is a patient in an institution for mental diseases (IMD). We proposed to use the Medicaid definition of IMD set forth at § 435.1009, which provides, in relevant part, that an IMD ''means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.''

We proposed to apply the IMD eligibility exclusion any time an eligibility determination is made, including the time of application or any periodic review of eligibility (for example, at the end of an enrollment period). Therefore, a child who is an inpatient in an IMD at the time of application, or during any eligibility determination, would be ineligible for coverage under a separate child health program. If a child who is enrolled in a separate child health program subsequently requires inpatient services in an IMD, the IMD services would be covered to the extent that the separate program includes coverage for such services. However, eligibility would end at the time of redetermination if the child resides in an IMD at that time. We stated that we were reviewing the IMD policy and considering various options. We solicited comments on an appropriate way to address this issue.

We proposed to use the Medicaid definition of ''inmate of a public institution'' set forth at § 435.1009. Accordingly, we stated in the preamble to the proposed regulation that when determining eligibility for a separate child health program, an individual is an inmate when serving time for a criminal offense or confined involuntarily in State or Federal prisons, jails, detention facilities, or other penal facilities. We also stated in the preamble to the proposed regulation that a facility is a public institution if it is run, or administratively controlled by, a governmental agency.

Under Medicaid, FFP is not available for medical care provided to inmates of public institutions, except when the inmate is a patient in a medical institution. We proposed to allow this same exception for a separate child health program because we believe an inmate residing in a penal institution who is subsequently discharged or temporarily transferred to a medical institution for treatment is no longer an ''inmate.'' Therefore, an inmate who becomes an inpatient in a medical institution that is not part of the penal system (that is, is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility that is not part of the penal system), would be eligible for a separate child health program (subject to meeting other eligibility requirements), and the State would receive FFP for medical care provided to that child. If the child is taken out of the medical institution and returned to a penal institution, the child again would be excluded from eligibility for the separate child health program.

Comment: Numerous commenters supported the proposed policy that a child would not be considered covered under a group health plan if the child did not have reasonable access to care under that plan and several others

requested further clarification. A third group of commenters also recommended that States should be allowed to determine when a plan is inaccessible.

Response: The intention of the ''reasonable access to care'' standard is to provide relief for children who are covered by a health maintenance organization or managed care entity not in close geographic proximity through the employer of a non-custodial parent and cannot get treatment in the locality in which they reside due to service area or other restrictions. HCFA recognizes that it is often difficult for such children to be removed from coverage under their non-custodial parent's health plan, because it is often court-mandated coverage and the custodial parent may not be able to terminate such coverage. We therefore defined these children as lacking ''reasonable access to care.'' While we recognize that health coverage that is unaffordable due to high premiums or deductibles also presents issues of access, the statute precludes children who are covered under a group health plan or under health insurance coverage (as defined under HIPAA and reflected in our definitions) from receiving coverage under a separate child health program. We note that some States have established eligibility for children whose families have dropped such unaffordable coverage and it is within their discretion to adopt such procedures. However, we believe that to permit children who are currently enrolled in a group health plan or other health insurance coverage, other than children who do not have reasonable geographic access to coverage, to enroll in a separate child health program would contradict the statute. We have revised § 457.310(b)(2)(ii) to clarify that a child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan.

Comment: Several commenters requested additional guidance on whether children covered under a plan which provides limited benefits only, such as policies covering only school sports injuries, vision, dental, or catastrophic care, or those with high deductibles, have access to insurance. One commenter requested that HCFA allow States to consider a child's access to dental services when making eligibility determinations. Clarification also was requested on whether school health insurance is considered creditable coverage.

Response: Section 2110(b)(1)(C) of the Act excludes from the definition of targeted low-income children a child who is ''covered under a group health plan or under health insurance coverage'' as those terms are defined in § 102 of the Health Insurance Portability and Accountability Act (HIPAA), which added section 2791 to the Public Health Service Act (PHSA), 42 U.S.C. 300gg–91(c). HIPAA and the implementing regulations (found at 45 CFR 146.145 and 148.220), in turn, exempt certain ''excepted benefits'' from some of the requirements of HIPAA to which group health plans and group health insurance are otherwise subject. Consistent with this treatment under HIPAA, a group health plan or group health insurance which meets the definition of ''excepted benefits'' also will not be considered as a group health plan or health insurance coverage for eligibility purposes. Under section 2110(b)(1)(C) of title XXI, a child with coverage under a group health plan or group health insurance coverage that is included under ''excepted benefits'' coverage may be provided with SCHIP funds, provided the child meets the other eligibility requirements of the separate program.

Policies that are limited to dental or vision benefits are among the ''excepted benefits'' identified in HIPAA. Therefore, a child with coverage under a limited-scope dental or vision plan would not be precluded from receiving coverage under a separate child health plan. Similarly, school health insurance policies with very restrictive coverage—for example, coverage limited to treating an injury incurred in a school sports event—would not preclude Title XXI eligibility, so long as they meet the definition of ''excepted benefits'' in HIPAA.

Comment: Two commenters requested that HCFA allow children to receive vision or dental services through a separate child health program when these services are not provided by the child's current health plan.

Response: With respect to coverage of vision and dental services, the statute does not permit States to provide coverage to children under separate child health programs when these children have other health insurance coverage, as defined by HIPAA even when coverage for certain services is limited. States that are concerned about ensuring that children receive such services may wish to consider expanding eligibility under Medicaid, which does not exclude children with other health insurance coverage from eligibility, or providing for such coverage with State-only funds.

Comment: One commenter noted that the exclusion of children of public employees places an additional administrative burden on States because they must verify whether the child has access to the State employee benefit system before a child may enroll in a separate child health program. Commenters also pointed out that under State welfare reform programs, many former welfare recipients are placed in entry-level State positions and State employee coverage is not necessarily affordable for them.

Response: We recognize that premiums and deductibles may present barriers to access to health coverage for children eligible for State health benefit coverage. However, the statute specifically prohibits coverage under a separate child health program of children who are eligible for health benefits coverage under a State health benefits plan. We have provided greater flexibility on this issue in the regulation, but we believe any further flexibility would violate the statutory prohibition. The verification requirements are subject to State discretion and the State may accept the individual's statement about eligibility for health benefits coverage under a State health benefits plan. Therefore, we do not agree that verification requirements necessarily create an undue burden on States. In any event, we do not have the statutory authority to permit eligibility for children of public employees who have access to coverage under a State health benefits plan.

Comment: Many commenters requested that HCFA clarify the proposed nominal contribution of $10 for children of public employees by indicating whether this is an amount per child, per family, per month, or per year. Other commenters offered alternative suggestions for what could be considered ''nominal,'' including: allow flexibility among states; $15–$20; 5% or 10% of the family's income or a standard related to their ability to pay; 25–50% of the child's premium; 50% of the cost of the child's coverage; or 60% of the cost of family coverage (consistent with the standard set for employer-sponsored insurance). One commenter requested clarification on how a nominal State contribution of $10 could be verified.

Response: We agree that we were unclear in the proposed regulation regarding the definition of nominal contribution and have clarified in the final regulation that the $10 contribution is per family, per month. While we appreciate the numerous suggestions submitted by commenters for alternative definitions of a ''nominal'' contribution, we did not change the $10 level in the final regulation. In selecting this level, we were attempting to offer States some

flexibility in determining what constitutes eligibility for a State health benefits plan, within the limits on eligibility for a separate child health program imposed by the statute. In our opinion, the $10 nominal contribution achieves this balance. We have also added to the regulation text the ''maintenance of effort'' provision discussed in the preamble to the proposed rule to indicate that if more than a nominal contribution was available on November 8, 1999, the child is considered eligible for a State health benefits plan. The contribution with respect to dependent coverage is calculated by deducting the amount the State or public agency contributes toward coverage for the employee only from the amount the State or public agency contributes toward coverage of the family.

For example, if a State contributes $100 per month to cover State workers themselves, but contributes $150 per month to cover the cost of the State workers themselves and their dependents, then the contribution toward dependent coverage would be $50 and would clearly exceed the $10 nominal contribution amount. A more complicated scenario that has arisen with certain States occurs when States offer flexible spending accounts in which employees are given a defined contribution amount and can choose from an array of health insurance options. Under these flexible spending plans, the State employees usually choose from plans that have a range of costs, some of which cost less than the State contribution, and some of which cost more than the State contribution. In such cases, if the State contributes $100 toward the cost of insuring the State workers themselves, and there are insurance options available that only cost $85 per month, then the extra $15 dollars that the employees keep could be used to cover the cost of dependents and would be considered a contribution toward family coverage that exceeded the $10 minimum contribution amount. If the cheapest health insurance option under such a scenario were $95, then the contribution toward dependents would be $5 and would be below the $10 nominal amount.

We also have clarified the language in § 457.310(c)(1)(i) to state that a targeted low-income child must not be eligible for coverage under a State health benefits plan on the basis of a family member's employment with a public agency even if the family declines to accept such coverage. We have clarified this language to reflect the clear intent of the statute that the child's eligibility for coverage is the determining factor in this case.

Comment: Several commenters requested clarification on the adoption of the Medicaid definition of ''inmate of a public institution.'' Commenters noted that, to date, the Medicaid policy has been unclear with unresolved issues, and one commenter queried whether the discussion in the preamble of the proposed regulations makes the stated policy official for Medicaid. Two commenters supported the policy that a child is no longer considered an inmate if the child is discharged from a public institution for treatment in a hospital. One commenter also requested that the term ''penal'' be included in the preamble and the regulation, and that the definition explain that this refers only to children who are incarcerated after sentencing. One organization requested that the term ''inmate of a public institution'' not be used because it makes it problematic for ensuring that children in the juvenile justice system, who are not always serving time for a criminal offense but may be awaiting trial, receive adequate care. The organization believes that there is no rationale for making ineligible a child who is temporarily confined.

Response: We have not accepted the commenters' suggestion to revise the definition of ''inmate of a public institution.'' This term is used in both title XIX and title XXI and is included in the Medicaid regulation at § 435.1009. For purposes of consistency it is appropriate that the term be defined for separate child health programs in these regulations as it has been defined in Medicaid.

Further, neither the statute nor the Medicaid definition differentiate between temporary confinement and incarceration after sentencing. However, as explained in the preamble to the NPRM, there is a distinction between the status of children under title XXI and under title XIX. Under title XXI, children who are ''inmates of a public institution'' are not eligible for a separate child health program. In contrast, under title XIX such children are eligible for Medicaid, but no FFP is provided for services provided while the child is in the institution. States may address the issue of temporary confinements by promptly enrolling or reenrolling children into the separate child health program when the child is discharged, as long as the child meets other eligibility requirements. We emphasize that the regulations in this subpart apply only to separate child health programs under title XXI. They do not establish Medicaid policy with respect to the definition of ''inmate of a public institution.''

Comment: We received many comments on the proposed policy related to a patient in an institution for mental diseases (IMD) and the requirement that a determination be made at the time of initial application or any redetermination. One State specifically supported this flexibility. Another pointed out that the proposed policy was inconsistent with the Medicaid policy and did not see why this situation was any different than other changes in living arrangements. Another said that the proposal to deny eligibility conflicts with § 457.402(a)(9) which includes IMD services in the definition of ''child health assistance,'' and that denial of eligibility is not a reasonable compromise between these two provisions. This commenter recommended that States be allowed to decide which provision best fits their programs. One commented that this provision of the regulation should be withdrawn because HCFA has not finalized its guidance for Medicaid. Several organizations disagreed with the proposed policy based on the potential negative effect on the child. One of these commenters recommended that the child remain eligible for a separate child health program until one year of creditable coverage has been secured for that child. One commented that it is unfair to cover some children and not others and that the policy on IMDs makes it very difficult to set accurate budget estimates and managed care rates. Another suggested that the exclusion apply only at the time of application so that the practitioner would not avoid referring a child for IMD services because the child might lose eligibility during his or her stay. This organization also said that this would allow consistent continued eligibility during an IMD stay for children who have been determined eligible for an SCHIP Medicaid expansion or separate child health program. Several commenters were concerned about continuity of care if the child lost eligibility at redetermination and commented that the policy was in conflict with the policy to allow a spend down when the spend down was met by the family paying for the IMD. Several commenters expressed support for the policy in the proposed regulation. One noted that children are often in an IMD for a short period. One organization commented that separate child health programs should continue to cover IMD services unless the child is determined not to be eligible for the program.

Response: We have carefully considered the range of comments on

this point and have adopted the policy set forth in the proposed rule as the final policy with respect to children who are patients in IMDs. As was described in the proposed rule, the IMD eligibility exclusion applies any time an eligibility determination is made, either at the time of application or during any periodic review of eligibility. We believe that this is the most reasonable interpretation of section 2110(b)(2)(A) of the Act, which excludes eligibility for residents in an IMD, in light of sections 2110(a)(10) and (18), which allow for coverage of inpatient mental health and substance abuse treatment services, including services furnished in a State-operated mental hospital. We also recognize that this policy may be perceived as treating children with similar needs inequitably based on the particular point in time at which their eligibility is being determined. However, we believe that this is the most reasonable way to implement the two statutory requirements cited above.

We recognize the concern raised by some commenters that this policy differs from Medicaid rules on the IMD exclusion, and in response we note that the different treatment is due to differences between title XIX and title XXI; title XXI mandates an eligibility exclusion for residents in an IMD, while title XIX provides for a restriction on payment for services provided to IMD residents. We must also point out that in Medicaid expansion programs, Medicaid rules will continue to apply and IMD residents will be eligible for the Medicaid expansion program, but no Federal matching funds will be available for any services provided to the individual while residing in an IMD, unless the facility meets the requirements of subpart D of 42 CFR 441 to qualify as an inpatient psychiatric facility for individuals under the age of 21.

5. Other Eligibility Standards (§ 457.320)

Section 2102(b)(1)(B) of the Act sets forth the parameters for other eligibility standards a State may use under a separate child health program. With certain exceptions, the State may establish different standards for different groups of children. Such standards may include those related to geographic areas served by the plan, age, income and resources (including any standards relating to spend downs and disposition of resources), residency, disability status (so long as any standard relating to disability does not restrict eligibility), access to other health coverage and duration of eligibility. We set forth these provisions at proposed § 457.320(a).

In addition, under the statute, the State may not use eligibility standards that discriminate on the basis of diagnosis, cover children with higher family income without covering children with a lower family income within any defined group of covered targeted low-income children, or deny eligibility on the basis of a preexisting medical condition. We set forth these provisions at § 457.320(b). We also proposed that States may not condition eligibility on any individual providing a social security number; exclude AI/AN children based on eligibility for, or access to, medical care funded by the Indian Health Service; exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens (except that, in establishing eligibility for a separate child health program, we proposed that States must obtain proof of citizenship and verify qualified alien status in accordance with section 432 of PRWORA); or violate any other Federal laws pertaining to eligibility for a separate child health program.

In addition to the revisions made to this section based on the comments discussed below, we clarified the language in § 457.320(b) to prohibit States from establishing eligibility standards or methodologies which would result in any of the prohibitions listed. ''Standards'' traditionally have referred to the income eligibility level (for example, 133 percent of the Federal poverty level). ''Methodologies'' includes the deductions, exemptions and exclusions applied to a family's gross income to arrive at the income to be compared against the standard in determining eligibility. This is a technical change necessary to implement the intent of the statute that States not be permitted to cover children in families with a higher income without covering children in families with a lower income.

Comment: One commenter expressed concern that allowing eligibility standards related to geographic area, age, income, resources, and so forth will allow States to limit the scope of coverage to a smaller population, thereby defeating the goal of covering the maximum number of children. They recommend that HCFA ensure that States are maximizing, not minimizing, the number of children covered. Two commenters were specifically concerned that standards related to geography might encourage States to exclude hard-to-serve areas such as rural areas, although they recognized this provision was statutory.

Response: The flexibility afforded to States in establishing eligibility standards was granted by Congress under section 2102(b)(1)(A) of the Act. Although a primary purpose of SCHIP is to extend health insurance coverage to as many uninsured children as possible, States are explicitly allowed by the law to adopt certain eligibility rules. We note that to date, States have generally designed and implemented broad coverage for children and we are hopeful that this will continue to be the case.

Comment: We received a few comments related to terminating benefits when a child reaches age 19. One commenter objected to terminating benefits when a child reached age 19, while another specifically supported doing so. A third commented that it would be clearer to say ''not to exceed 19 years of age'' than ''not to exceed 18 years of age.''

Response: Section 2110(c)(1) of the Act defines a ''child'' as an individual under 19 years of age. There is no statutory authority for payment to States for child health assistance provided to children who have reached age 19.

Comment: Several commenters expressed support for allowing States to define income and for allowing States flexibility in verifying income and establishing periods of review. One strongly supported allowing States to determine family composition as well as whose income will be counted and under what circumstances, because this approach could provide a basis for teens (without family support) to enroll themselves.

Response: We appreciate the support and agree that allowing States to define ''family'' and ''income'' might provide States the flexibility to provide coverage to certain teens who are without family support.

Comment: One commenter requested that HCFA point out the advantage of using the same definition of income for separate child health programs and Medicaid.

Response: We urge States to use the same definition of income and the same methods of determining income for both separate child health programs and Medicaid. As discussed later in this preamble, using the same definitions and methodologies simplifies the screening process and helps ensure that children are enrolled in the correct program. HCFA can help States to identify ways to simplify Medicaid methodologies and to align the rules adopted for Medicaid and a separate child health program.

Comment: One commenter expressed concern that allowing States to use gross

or net income as countable when determining whether the countable income is below the eligibility standard will result in State differences and families may be convinced to move to another State for coverage.

Response: Given the flexibility authorized by law, income tests would vary from State to State even if States were required to use the same method of arriving at countable income because the income standards to which the countable income is compared vary widely. Income standards (and often methodologies) for most Federally-assisted, means-tested programs vary from State to State. Research in this area indicates that individuals move to be with family or for employment and generally do not move for the purpose of receiving means-tested benefits. Income standards vary widely in Medicaid and there has been no evidence that this has resulted in families moving from State to State.

Comment: Two commenters specifically supported eliminating pre-existing conditions as a reason for denial and stated that such a policy is important to children with special needs. Two additional commenters stated that if States may not deny eligibility based on preexisting conditions, it may conflict with contracts between a separate child health program and a health plan or with premium assistance programs.

Response: Section 2102(b)(1)(B)(ii) of the Act prohibits the denial of coverage based on preexisting conditions and § 2103(f)(1)(A) prohibits eligibility restrictions based on a child's preexisting condition. We agree that this prohibition is very important in providing health care to low-income children with special needs and have included it at § 457.320(b)(2) of the regulations. States that have contracts with health plans which restrict eligibility based on preexisting conditions will have to renegotiate the contracts or otherwise ensure that the affected children are provided with care that meet the standards of title XXI.

One limited exception to this rule is permitted. Under § 2103(f)(1)(B) of Title XXI, if a State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance, the plan may permit the imposition of those preexisting conditions which are permitted under HIPAA. This permits the imposition of preexisting conditions consistent with the requirements of such plans when the State is providing premium assistance through SCHIP to subsidize child or family coverage under a group health plan or group health insurance pursuant to § 2105(c)(3) of the statute.

Comment: We received one comment specifically supporting State latitude to establish eligibility based on State-established disability criteria. Another commenter recommended that we add a new § 457.320(b)(4) to specifically prohibit the use of eligibility standards that discriminate on the basis of diagnosis in accordance with section 2102(b)(1)(A).

Response: Section 2102(b)(1)(A) of the Act provides that an eligibility standard based on disability may not ''restrict eligibility,'' although States may provide additional benefits to children with disabilities. This provision was included in the regulation at § 457.320(b)(3). Section 2102(b)(1)(A) of the Act also provides that no eligibility standard may discriminate on the basis of diagnosis. We have revised the regulation at § 457.320(b)(3), as suggested, to specifically prohibit discrimination on the basis of diagnosis. Therefore, a State may establish eligibility standards that are based on or related to the loss of certain functional abilities, whether physical or mental, if those standards result in children with disabilities qualifying for coverage. A State cannot, however, establish eligibility standards based on or related to a specific disease.

Comment: We received a significant number of comments urging HCFA to add specific residency requirements. Many of the commenters were concerned about children of migrant workers and homeless children. One commenter specifically urged HCFA to require States to set forth rules and procedures for resolving residency disputes. One recommended that the regulations explicitly provide that families involved in work of a transient nature be allowed to choose to establish residency in the State where they work or in one particular State. One commenter recommended that States be required to expedite enrollment of migrant children. One recommended that States be prohibited from the following: denying eligibility to a child in an institution on the grounds that a child did not establish residency in the State before entering the institution; denying or terminating eligibility because of temporary absence; or denying eligibility because residence was not maintained permanently or at a fixed address.

Response: Because Congress has specifically allowed States flexibility to establish standards, we do not establish general residency rules for States. However, we share the commenters' concern that certain children may be unable to establish eligibility in any State because of disputes over residency and do not believe that allowing such a result would be consistent with the overall intent of title XXI and the requirement that SCHIP be administered in an effective and efficient manner. We have revised paragraph (a)(7) and added a new paragraph (d) to § 457.320 to specify residency rules in limited circumstances. In the case of migrant workers, when the child of a parent or caretaker who is involved in work of a transient nature, such that the child's physical location changes periodically from one State to another, the parent or caretaker may select either their home State or the State where they are currently working as the State of residence for the child. For example, if a migrant family moves temporarily from Florida to North Carolina and then returns to Florida during the course of a year as a result of the parents' transient employment, the parents can claim either Florida or North Carolina as the child's State of residence.

In other instances, where two or more States cannot resolve which is the State of residence, the State where a non-institutionalized child is physically located shall be deemed the State of residence. In cases of disputed residency involving an institutionalized child, the State of residence is the parent's or caretaker's State of residence at the time of placement. We believe that a child who is placed in an out-of-State institution should remain the responsibility of the State of residence at the time of placement. Similarly, in cases of disputed residency involving a child who is in State custody, the State of residence is the State which has the legal custody of the child. As indicated in the preamble to the proposed rule, under Shapiro v. Thompson (394 US 618), a State cannot impose a durational residency requirement. We have also added this prohibition to § 457.320(d).

We have not imposed further residency rules. However, we strongly recommend that States establish written inter-State agreements related to disputed residency. We note that the rules contained in § 457.320(d)(2) of this regulation apply only if the States involved cannot come to agreement with respect to a child's residency.

Comment: We solicited comments on our proposal that the eligibility standard relating to duration of eligibility not allow States to impose a maximum length durational requirement or any similar requirement. We received three comments in response, and all three recommended that the regulations make it clear that States are prohibited from

imposing time limits or lifetime caps on eligibility.

Response: Under section 2102(b)(1)(A) of the Act, States have considerable flexibility in setting the standards used to determine the eligibility of targeted low-income children, including those related to duration of eligibility. This enables States to establish the period of time for which a child determined eligible for the State's separate child health program can remain covered prior to requiring a redetermination or renewal of eligibility. At the same time, it is important to ensure that States can identify children enrolled in a separate child health program who become ineligible due to a change in circumstances. Therefore, we have retained the provision in proposed § 457.320(a)(10) and moved it to § 457.320(e)(2) to require that States redetermine a child's eligibility at least every 12 months. Note that termination of a child's eligibility at the end of the specified period (e.g. after a redetermination review) would constitute a ''denial of eligibility'' subject to the requirements of § 457.340(d) of this subpart and subpart K.

We agree that durational limits on eligibility are contrary to the intent of the program. We have added a new subsection § 457.320(e)(1) to include a prohibition against imposing time limits, including lifetime caps, on a child's eligibility for coverage. That is, a State cannot deny eligibility to a child because he or she has previously received benefits. The prohibition against lifetime caps or other time limits on coverage is consistent with Congressional intent to provide meaningful health care for children and will prevent unequal treatment of similarly-situated children simply because one child has been enrolled in the program longer than the other. It will also prevent the possibility of jeopardizing the health of low-income children by terminating or denying health care on the basis of circumstances unrelated to the child's needs. The prohibition against durational limits on eligibility does not prevent a State from limiting enrollment based on budget constraints, or capping overall program enrollment due to lack of funds. This is reflected in §§ 457.305(b) and 457.350(e). In addition, we have added a definition of ''enrollment cap'' in § 457.10 of subpart A.

Comment: One commenter specifically supported the concept of 12 months of continuous eligibility. Another recommended that the regulations be more specific about the duration of eligibility. This commenter recommended an annual time period because health care should not be interrupted when income fluctuates, which the commenter believes happens frequently with the population being served. One commenter objected to requiring any interim screening process during an established 12-month continuous eligibility period.

Response: We see no basis to prohibit State review of eligibility on a less than annual basis. We do encourage States to establish an annual period of review and to adopt continuous eligibility rules to avoid interruptions in a child's health care because of minor fluctuations in income. Frequent reviews can be a barrier to enrollment and redetermination and can reinforce the ''welfare stigma.'' In addition, research shows that many children lose coverage at the time of redetermination.

Between the scheduled reviews, regular, periodic screenings are not required. A child always has the right to file for and become eligible for Medicaid if family income changes, and the State is required to take action on the application, even if the child is covered by a separate child health program. If a child enrolled in a separate child health program does not file an application for Medicaid, the State is not required to screen the child for Medicaid eligibility until the next scheduled redetermination, regardless of changes in the child's circumstances (other than reaching age 19).

Comment: We received a significant number of comments on the discussion about pregnant teens included in the preamble, many of which expressed support for our position.

One commenter suggested that Illinois KidCare is a good model under which a pregnant teen is automatically transferred to the Moms and Babies Medicaid Program. Another recommended that HCFA clearly state an expectation that States provide information to teenage enrollees on the possible benefits of seeking Medicaid if they are pregnant, rather than simply urging them to do so. One commenter recommended that States be required to inform pregnant teens about the differences between their Medicaid and separate child health programs. This commenter also asserted that the benefits of keeping a trusted health care provider may override the benefits of broader coverage and lower out-of-pocket expenses and that States, therefore, should inform pregnant teenagers of the possibility that changing from one program to the other may require the teen also to change doctors. Two commenters recommended that it be made clear that States providing information about Medicaid and the opportunity to apply for Medicaid cannot be held responsible for any individual who does not complete the Medicaid application process.

Several commenters objected to the recommendation that pregnant teens switch to Medicaid midyear. They argued that this unnecessarily disrupts continuity of care and has negative effects on pregnant teens. One of these commenters recommended that pregnant adolescents in their second or third trimester and adolescents with high-risk pregnancies be allowed to continue to see their treating provider through pregnancy and the 60-day postpartum period. Another commenter stated that the regulation related to monitoring pregnant teens and moving them to Medicaid in the middle of an eligibility period goes beyond statutory authority.

One commenter contended that all benchmark programs require pregnancy services and commented that establishing procedures for managed care contractors to notify the State of a teen's pregnancy would be cumbersome, expensive and a potential violation of the family's confidentiality.

Finally, one commenter was concerned that the discussion about pregnant teens not appear to foreclose separate child health programs from adopting pregnancy-related benefits for pregnant teens who are not eligible for Medicaid.

Response: We appreciate the comments, and we wish to clarify a number of points. In drawing attention to pregnant teens, it was not our intent to impose additional or unnecessary requirements on States nor to promote procedures that would disrupt the medical care of pregnant teens. Our intent was to ensure that pregnant teens are provided with sufficient, clear information about Medicaid to make an informed choice about staying in the separate child health program or applying for Medicaid. States are not required to monitor teens for pregnancy and cannot be held responsible for teens who choose not to apply for Medicaid. Managed care contractors in separate child health programs are not required to notify the State when a teen becomes pregnant. Finally, States may provide the same pregnancy-related services under separate child health programs that they do under Medicaid. We urge States to do this, but pregnancy-related services are not mandatory under separate child health programs. We also urge States to make every effort to rely

on the same plans and providers in their separate child health programs and Medicaid so that children who switch between programs because of changes in circumstances, including pregnancy, need not change providers.

While States are not under an obligation to ensure that teens enrolled in separate child health programs become enrolled in Medicaid if they become pregnant, we remind States that there are advantages to Medicaid for a pregnant teen even when the benefit package is the same. First, cost-sharing is prohibited for pregnancy-related services under Medicaid and premiums are prohibited if the woman's net family income is at or below 150 percent of the Federal poverty level. (Above that level premiums are limited to 10 percent of the amount by which the family income exceeds 150 percent of the Federal poverty level.) In addition, a child born to a woman who is eligible for and receiving Medicaid on the day the infant is born is deemed to have filed an application and been found eligible for Medicaid. That infant remains eligible for one year if residing with the mother, regardless of family circumstances. If the delivery is covered by a separate child health program because the mother does not apply for Medicaid, the infant might not be eligible for Medicaid instead of automatically eligible as would be the case had the delivery been covered by Medicaid.

Comment: Two commenters recommended that HCFA encourage States that have separate child health programs to provide newborn infants the same eligibility protections granted under Medicaid. Another recommended that HCFA allow pre-enrollment of newborns or automatic enrollment of newborns of pregnant teens enrolled in a separate child health program.

Response: The statute does not provide for automatic and continuous eligibility for infants under a separate child health program as it does under Medicaid. Moreover, it is also likely that due to higher income standards that most States apply in Medicaid, many infants born to teens enrolled in a separate child health program will be eligible for Medicaid and therefore not eligible for a separate child health program.

However, as discussed elsewhere in this preamble (in response to comments under both §§ 457.300 and 457.360), we have determined that States may use ''presumptive eligibility'' to enroll children in a separate child health program pending completion of the application process for Medicaid or the separate plan. We recognize the need of infants to have immediate coverage and consider the automatic enrollment of newborns born to mothers covered by a separate child health program at the time of the delivery into the separate program as an example of such presumptive eligibility. Presumptive eligibility is time-limited, however, and States choosing to enroll these newborns must formally determine the infant's eligibility (including screening the infant for Medicaid eligibility) within the time frame set for completing the application process and determining eligibility.

As noted earlier, if the infant is ultimately found not to be eligible for Medicaid, costs of services provided during the period of presumptive eligibility may be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. Thus, States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

Alternatively, States can develop an administrative process to identify, prior to birth, an infant as a Medicaid-eligible individual as soon as he or she is born, as we understand some States have done. This would ensure that Medicaid coverage and services are immediately available to a Medicaid-eligible newborn child.

Comment: We received a large number of comments related to obtaining social security numbers (SSNs) during the application process. Many commenters specifically supported the prohibition against requiring the SSN in separate child health programs. Two requested clarification as to whether an SSN can be required on a joint SCHIP/Medicaid application. A few recommended that SSNs be required for applicants as long as there is a Medicaid screen and enroll requirement. One commenter did not advocate asking for an SSN, but commented that the policy for separate child health programs and Medicaid should be consistent because families prefer to give all information at one time and having a distinction between the requirements for the two programs hinders States' efforts to create a seamless program.

Some commenters indicated that the prohibition against requiring SSNs for a separate child health program while requiring it for Medicaid will cause referral, tracking and coordination problems; handicap enrollment in States using a joint application; make it difficult to implement the screen and enroll provision; reinforce stereotypes; and prevent automatic income verification in States that have reduced the documentation requirements. Another added that this prohibition will impede efforts to identify children with access to State health benefits.

Finally, another commenter suggested that Medicaid medical support cooperation requirements include providing information about noncustodial parents and that this ''section may be construed as excusing a Medicaid applicant from having to provide an SSN for all family members, including noncustodial parents absent from the home.''

Response: The requirements and prohibitions related to the use of a social security number are statutory. The Privacy Act makes it unlawful for States to deny benefits to an individual based upon that individual's failure to disclose his or her social security number, unless such disclosure is required by Federal law or was part of a Federal, State or local system of records in operation before January 1, 1975. Section 1137(a)(1) of the Social Security Act requires States to condition eligibility for specific benefit programs, including Medicaid, upon an applicant (and only the applicant) furnishing his or her SSN. Because SCHIP is not one of the programs identified in section 1137 of the Act, and Title XXI does not require applicants to disclose their SSNs, States are prohibited under the Privacy Act from requiring applicants to do so.

Thus, only the SSN of the individual who is applying for Medicaid (including a Medicaid expansion program under title XXI) can and must be required as a condition of eligibility. Children applying for coverage under a separate child health program cannot be required to provide a SSN, and States cannot require other individuals not applying for coverage, including a parent, to provide a SSN as a condition of the child's eligibility for either a Medicaid expansion program or separate child health program.

We recognize that these statutory provisions can be difficult to reconcile in practice. Under the law, a joint Medicaid/SCHIP application must indicate clearly that the SSN is only needed for Medicaid and not for coverage under a separate child health program, but a family often will not know if their child is or is not Medicaid-eligible. A State may request the SSN for all applicant children as long as the State makes it clear that family members are not required to provide the SSN and that the child's eligibility under the

separate child health program will not be affected if the child's SSN is not provided. However, the State must also inform the family that Medicaid eligibility cannot be determined without the SSN and that the child cannot be enrolled in the separate child health program if the child otherwise meets the eligibility standards for Medicaid.

Comment: A significant number of commenters objected to the verification requirements pertaining to citizenship and alien status. Most of these commenters requested that subsection § 457.320(c) be deleted. A number of the commenters pointed out that we proposed to require that States follow INS rules which were not yet mandatory. Additionally, they argued that the requirement in § 457.320(b)(6) that States abide by all applicable Federal laws and regulations would be sufficient. Several commenters objected to the verification requirements for a number of reasons. A significant number of them commented that the procedures are too burdensome. One commenter felt that proof of citizenship might discourage some citizens who do not have birth certificates from applying. Another commented that requiring proof and verification of alien status would delay access to care for alien children who are otherwise eligible.

Response: Section 432 of the PRWORA requires verification of citizenship for applicants of all ''Federal public benefits'' as defined in section 401 of the PRWORA. However, proposed regulations published by the Department of Justice, which is responsible for enforcing the verification provision, provide that a State may accept self-declaration of citizenship provided that (1) the federal agency administering the program has promulgated a regulation which permits States to accept self-declaration of citizenship and (2) the State implements fair and nondiscriminatory procedures for ensuring the integrity of the program at issue with respect to the citizenship requirement.

Requiring documented proof of citizenship can be a time-consuming and difficult process for many applicants, and therefore could create a significant barrier to enrollment. It also can create a significant administrative burden for the State. Therefore, consistent with the statutory intent to promote access to and enrollment in separate child health programs and HCFA's policy to provide States with flexibility to simplify their application processes and eliminate barriers to enrollment wherever possible, we have modified § 457.320(c). The regulation permits States to accept self-declaration of citizenship, provided that they have implemented effective, fair and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

For example, a State could implement a system to randomly check the documentation of some applicants and terminate the eligibility of any applicants found to have provided a false declaration. If the percentage of false declarations was found to be high, the State would need to take appropriate measures to remedy the problem—including, if necessary, requiring documentation to verify the citizenship of every applicant.

Comment: One commenter asked for clarification of the difference between ''proof'' and ''verification.''

Response: We have used ''proof'' to refer to documents provided by individuals. ''Verification'' is used to refer to the process of comparing the information in the ''proof'' to the INS records. An individual may be considered eligible based on ''proof'' while the information is being verified.

Comment: Several commenters urged that the regulations specifically prohibit requests for information about the citizenship or immigration status of non-applicants, including parents. One commenter indicated that States should be prohibited from verifying the status of any non-applicant when the information is voluntarily provided.

Response: Information about the citizenship or alien status of a non-applicant cannot be required as a condition of eligibility. States may request this information if it reasonably relates to a State eligibility standard and it is made clear that the provision of this information is optional and that refusing to provide the information will not affect the eligibility of applicants. We strongly urge States not to request this information nor to verify it if voluntarily provided, as this has been found to be a strong deterrent to alien parents filing applications on behalf of their citizen children.

Comment: One commenter recommended that HCFA issue, through letter or manual and web site, Medicaid guidance on the categories of immigrants eligible for Medicaid and that these regulations reference that guidance.

Response: Section 3210 of the State Medicaid Manual, which is available through links set for in HCFA's web site at *www.hcfa.gov,* discusses immigrant eligibility for Medicaid following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, although it does not reflect changes to immigrant eligibility contained in the Balanced Budget Act of 1997. We also have posted a fact sheet on the section of our web page addressing Medicaid and welfare reform. The fact sheet is entitled, ''The Link between Medicaid Coverage and the Immigration Provisions of the Personal Responsibility and Work Opportunity Act of 1996.'' Guidance to State Medicaid Directors dated December 8, 1997 discusses changes in immigrant eligibility for Medicaid under the Balanced Budget Act of 1997. Finally, guidance dated January 14, 1998 discusses immigrant eligibility for benefits under title XXI. This guidance (in the form of ''Dear State Medicaid Director or Dear State Health Official letters) can be found at *www.hcfa.gov.*

We will consider issuing more detailed instructions pertaining to the eligibility of immigrants for Medicaid and separate child health programs and posting such guidance on our web site.

6. Application and Enrollment in a Separate Child Health Program (§ 457.340)

We proposed to require that the State afford every individual the opportunity to apply for child health assistance without delay. Section 2101(a) of the Act requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program. Because we have determined that proposed § 457.361 ''Application for and enrollment in SCHIP,'' is closely related to this section, in this final rule we have incorporated the provisions of proposed § 457.361 into this section. We will respond to the comments concerning § 457.340 of the proposed rule here, and to those concerning § 457.361 of the proposed rule below, under § 457.361.

Comment: We received a number of comments on this section. Many commenters were concerned about the complexity of the application process, particularly when States have a separate child health program. Several commenters recommended that HCFA require States to certify that they have conducted a review of their Medicaid and Title XXI application and redetermination procedures and have eliminated any unnecessary procedural barriers that discourage eligible children from enrolling in and retaining coverage. If differences remain, States should be required to identify in their State plan the reasons for the differences and explain how they are consistent with the coordination goals of title XXI.

Other commenters added that families should not be forced to understand and navigate two sets of application, enrollment and redetermination procedures.

Several commenters focused on joint applications for Medicaid and separate child health programs. One commenter asked HCFA to highlight that States can use a joint application and a single agency. Another urged HCFA to require a joint application process or, at a minimum, to conduct rigorous oversight of the screen and enroll procedures. A third specifically indicated that HCFA should require States to have a single form for children who are applying for both programs, that it be limited to four pages, that States be required to accept mail-in applications and that States notify families when their application has been received. Yet another stated that the burden should rest with the State that chooses not to have a joint application to establish that its application procedures are effective. This commenter also recommended that HCFA require that the same verification procedures be used for both programs and that families not have to take any additional steps in order for their application to be processed by Medicaid.

One commenter felt that the regulations should define a joint application process rather than referring to joint forms. This commenter believes that applicants should be subject to the same requirements and procedures—including a single application, the same verification requirements, and common entry points—for both programs, and that nothing additional should be required for children to enroll in Medicaid under one of the categories identified in § 457.350(c)(2).

One commenter felt that States also should be required to certify that they have eliminated any unnecessary procedural barriers to children making a transition between regular Medicaid and a Title XXI-funded program when they lose eligibility for one program and become eligible for the other. Another thought it would be useful for HCFA to mention that flexibility regarding the eligibility determination process is not limited to contractors. Provider employees or outstationed workers at provider locations are also capable of making these determinations under a separate child health program.

Two commenters emphasized the importance of States applying any simplifications adopted in the application process for Medicaid or a separate state program to children whose families also are on Food Stamps or TANF. Some States which generally allow families to apply for Medicaid on behalf of their children through a mail-in application reportedly do not accept mail-in applications from families who already happen to be receiving Food Stamps or TANF. In this commenter's view, such policies create inequities and impose unnecessary procedural barriers to Medicaid enrollment and HCFA should encourage States to review whether they have any such policies, and to eliminate them whenever possible.

Other commenters recommended that HCFA place emphasis not only on helping families to apply for coverage, but also on helping them to remain enrolled in coverage. They felt that the simplification strategies listed by HCFA should also include States' adopting the same redetermination period in Medicaid and separate child health programs, and reducing verification requirements for redeterminations as well as for the initial application.

Response: States are required to establish a program that is ''effective and efficient'' and a process that allows every individual to apply for child health assistance without delay. Mail-in, joint program application forms, common entry points and applicable procedures, single agency oversight and administration, and simplified and consistent program rules and documentation requirements are several ways that States can facilitate families' ability to apply for the appropriate health coverage program as expeditiously as possible. These procedures can also simplify administration for States. While we are not requiring that States use any specific mechanism, States that do not take steps to streamline, align, and coordinate their enrollment process will have a more difficult time ensuring that children can apply for health insurance coverage without delay and that their application is assessed in an effective and efficient manner.

We encourage, but do not require, States to use a joint application for their separate child health program and Medicaid programs and to simplify the application as much as possible. We agree with the comment that States should construct a joint application process, rather than just a joint application. States that have adopted the same or similar rules relating to application interviews, verification and managed care enrollment have an easier time coordinating the enrollment process. We note that most States with separate child health programs report they use a joint child health application and that joint applications do not necessarily need to cover all possible Medicaid eligibility groups.

Section 2102(c) requires coordination of the administration of SCHIP with other public and private health insurance programs, and we also will be monitoring States' coordination of enrollment in their separate child health program and Medicaid programs, including children's transitions from one program to the other. HCFA will pay particular attention to outcomes in States that lack many of the elements of a streamlined and coordinated system. When appropriate, such monitoring will include requests for States to identify the number of children found potentially eligible for Medicaid, the percentage of those children who have been determined eligible for and enrolled in Medicaid, and the percent determined eligible for and enrolled in the separate child health program. These data will help States and HCFA determine whether the State has developed an effective method to coordinate enrollment and ensure that children are enrolled in the appropriate program.

While States have and will continue to have the flexibility to design their own unique application and enrollment systems, States will be held accountable to ensure that children are afforded the opportunity to apply for the appropriate program in a timely and efficient manner. We believe that most States have developed coordinated enrollment procedures and are continuing to improve their systems to promote enrollment of eligible children, and we will continue to work with the States in developing effective systems.

It is also true, as a few commenters pointed out, that eligibility determination for a separate child health program may be performed by a wide range of entities, as determined by the State. For example, State Medicaid agencies, health care plans and providers, and outstationed State or local eligibility workers also may determine eligibility.

Finally, we agree with the last two points made by the commenters. First, we agree that States' simplifying both initial application and redetermination processes is critical. Second, we also agree that States can reduce barriers to accessing health care for all families by applying any simplifications adopted in the application process for Medicaid and the separate child health program to the application process for children whose families also happen to be receiving, or applying for, Food Stamps or TANF benefits, and we encourage States to do so.

Comment: Several commenters requested that States be given flexibility to use the application for a program other than Medicaid or SCHIP.

Response: States may use a joint application with other programs. Proposed § 457.340(b) was confusing and may have implied that States do not retain discretion over whether or not to combine the applications of different programs. Because we do not want to preclude States from including programs other than Medicaid and SCHIP in a joint application and because a regulation is not needed to allow States to adopt a joint application, we have eliminated § 457.340(b). This in no way implies that States are prohibited from using joint applications. In fact, we continue to strongly encourage States to consider how joint applications might promote coverage of eligible children.

For example, the application for Medicaid and/or a separate child health program may be combined with an application for child care assistance or WIC. Joint applications can be an effective outreach and enrollment tool because they can help States reach families that are being served by other programs. States that use a joint application, however, must develop a process that allows every individual to apply for child health assistance without delay. If the application for the separate child health program and/or Medicaid is combined with an application for other services or benefits and sufficient information is provided to make a determination of eligibility for child health coverage, that determination must not be held up because of information (or action) which is needed for the other program. Joint program applications, while an effective tool, must not result in delays that would be contrary to the intent of the statute and this section.

Comment: One organization commented that the regulations should clarify that underlying the provision at proposed § 457.340(a) regarding the opportunity to apply without delay are title VI of the Civil Rights Act and the Americans with Disabilities Act.

Response: Underlying the provision that individuals be able to apply without delay is section 2101(a) of the Act, which requires States to provide child health assistance to uninsured, low-income children in an effective and efficient manner. The opportunity to apply without delay is necessary for an effective and efficient program.

Of course, this opportunity must be available to all children, regardless of their race, sex, ethnicity, national origin or disability status. Thus, the civil rights laws must be adhered to in implementing this requirement, but are not the only statutory authority for this provision.

Comment: One commenter expressed strong support for the requirement that every individual be afforded the right to apply. The commenter asserted that adolescents not living with their parents should be allowed to file their own applications and recommended that HCFA, through the preamble, encourage States to adopt policies that facilitate the filing of applications by adolescents themselves.

Response: As required by this section, States must afford every individual, including adolescents, the opportunity to apply for child health assistance without delay. We encourage States to consider how they might best ensure that adolescents, including those who are not living with their parents or caretakers, can apply for SCHIP. States can also allow adolescents to sign their own applications; but this is a matter of State law and we cannot require States to permit minors to do so.

Comment: One commenter stated that the regulations should address methods for allowing families to report changes in circumstances in an efficient, family-friendly manner, such as not requiring the family to complete a new application when circumstances change.

Response: Section 2101(a) of the Act requires that child health assistance be provided in an effective and efficient manner. A reporting system which requires that a child reapply every time there is a change in family circumstances affecting eligibility would not constitute effective and efficient administration. The precise manner in which an individual reports changes is subject to State discretion, as is the form used for periodic redetermination. States should develop methods of reporting changes that pose as few barriers to uninterrupted eligibility as possible and do not require families to resubmit information that has not changed. States that have opted to provide continuous eligibility generally do not require reporting of any changes in circumstances except at regularly scheduled redeterminations.

7. Eligibility Screening and Facilitating Medicaid Enrollment (§ 457.350)

Sections 2102(b)(3)(A) and (B) of the Act require that a State plan include a description of screening procedures used, at intake and at any redetermination, to ensure that only children who meet the definition of a targeted low-income child receive child health assistance under the plan, and that all children who are eligible for Medicaid are enrolled in that program. In accordance with the statutory provisions, we proposed at § 457.350(a) that a State plan must include a description of these screening procedures.

More specifically, section 2110(b)(1)(C) of the Act provides that children who would be eligible, if they applied, for Medicaid are not eligible for coverage under a separate child health program. Section 2102(b)(3)(B) provides that States have a responsibility to actually enroll children who have applied for a separate child health program in Medicaid if they are Medicaid-eligible.

As stated in previous guidance, referrals to Medicaid do not satisfy this ''screen and enroll'' requirement. In accordance with the statute, we proposed to require States to use screening procedures that identify any child who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act. However, since States are not mandated to cover children below the age of 19 who were born before October 1, 1983 under the poverty-level-related Medicaid groups, we also proposed at § 457.350(c) to require, at a minimum, that a State use screening procedures that identify any child who is ineligible for Medicaid under the poverty level related groups solely because of age but is potentially eligible under the highest categorical income standard used under the State's title XIX State plan for children under age 19 born before October 1, 1983. In almost all circumstances, we expected that the highest categorical income standard used for such older children will be the standard used for the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act. These children are sometimes referred to as ''Ribicoff children.'' (See § 435.222.) Mandatory coverage of the older children in poverty-level related groups is being phased in and by October 1, 2002, all children under age 19 will be included in the poverty-level-related groups in all States.

In the preamble of the proposed rule, we encouraged States to identify any pregnant child who is eligible for Medicaid as a poverty-level pregnant woman described in section 1902(1)(1)(A) of the Act even though she is not eligible for Medicaid as a child. We noted that Medicaid coverage, cost-sharing rules and eligibility rules pertaining to infants may be more advantageous to a pregnant teen than coverage under a separate child health program.

We proposed at § 457.350(d) that to identify children who are potentially eligible for Medicaid, States must either initially apply a gross income test and then use an adjusted income test for applicants whose State-defined income exceeds the initial test, or use only the adjusted income test for all applicants. We set forth the initial gross income test and the adjusted income test at proposed § 457.350(d)(1) and (2) respectively.

As indicated in section 2102(b)(3)(B) of the Act, Congress intended that children eligible for Medicaid be enrolled in the Medicaid program. We proposed at § 457.350(e)(1) that, for a child found potentially eligible for Medicaid, the State must not enroll the child in the separate child health program unless a Medicaid application for that child is completed and subsequently denied.

At § 457.350(e)(2) we proposed that the State must determine or redetermine the eligibility of such a child for the separate child health program if (1) an application for Medicaid has been completed and the child is found ineligible for Medicaid or (2) the child's circumstances change and another screen shows the child is ineligible for Medicaid. Finally, at § 457.350(e)(3), we proposed that if a child is found through a State screening process to be potentially eligible for Medicaid but fails to complete the Medicaid application process for any reason, the child cannot be enrolled in a separate child health program. Enrollment in a separate child health program for such a child can occur only after the Medicaid agency determines that a child who has been screened and found likely to be eligible for Medicaid is not in fact eligible for Medicaid under other eligibility categories.

We also proposed to require at § 457.350(f) (§ 457.350(g) in this final regulation) that States choosing not to screen for Medicaid eligibility under all possible groups provide certain written information to all families of children who, through the screening process, appear unlikely to be found eligible for Medicaid. We proposed that the following information must be provided to the person applying for the child: (1) a statement that, based on a limited review, the child does not appear to be eligible for Medicaid but that a final determination of Medicaid eligibility can only be made based on a review of a full Medicaid application; (2) information about Medicaid benefits (if such information has not already been provided); and (3) information about how and where to apply for Medicaid.

We have incorporated the provisions of proposed § 457.360, ''Facilitating Medicaid enrollment,'' into § 457.350 because the requirements of both sections relate to the steps which the State or contractor responsible for determining eligibility under a separate child health program must take to comply with the ''screen and enroll'' requirements of Title XXI. In § 457.350(a), we therefore have added a requirement that the State plan include a description of the procedures the State will use to ensure that enrollment in Medicaid is facilitated for children screened potentially eligible for Medicaid and who are then determined by the State Medicaid agency to be eligible for Medicaid.

We will respond to the comments on the proposed § 457.360 in our discussion of § 457.360 rather than in our discussion of this section. Also, note that the obligations of the Medicaid agency in meeting the screen and enroll requirements are set forth in a new § 431.636, which is discussed further in subpart M of this preamble, ''Expanded coverage of children under Medicaid and Medicaid coordination.''

We noted in the preamble that there is great concern among a number of States and others that children will go without health care because of these screen and enroll policies. The concern centers around the perceived stigma of Medicaid. Some families may refuse to apply for Medicaid because they associate it with ''welfare.'' Some families may not complete the Medicaid application process because it may be more complicated than the application process for a separate child health program, may require more documentation, or may otherwise be seen as more invasive into personal lives. We solicited comments on the extent of these problems and possible solutions. We received many comments concerning the screen and enroll requirements. These comments are addressed below.

Comment: One commenter indicated that the term ''found eligible'' should be used consistently. The regulations should not say that a child is ''found eligible'' for Medicaid through the screening process and then indicate that when the Medicaid application is processed the child is not ''found eligible'' for Medicaid.

Response: We agree with the comment. A child who has been found through the screening process to be potentially eligible for Medicaid has not been determined eligible for Medicaid. We have revised the regulations to use the terms consistently. As revised, the term ''found eligible'' is only used when a final action has been taken on a Medicaid application and the child has been enrolled in Medicaid. The term ''potentially eligible'' is used when a screening indicates that a child appears to be eligible for Medicaid and therefore may not be enrolled in a separate child health program until action is taken on his or her Medicaid application.

Comment: One commenter suggested that the regulations require that States provide comprehensive training to eligibility determination workers (and other workers as appropriate) in both Medicaid and a separate child health program to ensure that all potentially eligible applicants are afforded the right to apply and that no eligible children are terminated inadvertently or inappropriately.

Response: One aspect of minimizing barriers and assuring appropriate action with respect to applications is providing adequate training to eligibility workers. States will need to ensure that such training has been, and continues to be, provided, as appropriate.

Comment: A significant number of commenters supported the policy that a child could be ''found ineligible'' for Medicaid through either a regular Medicaid application or through a screening rather than requiring that an actual Medicaid application be filed and a formal determination be made that the child is Medicaid-ineligible.

Response: The clear intent of title XXI is to provide benefits only to children who do not meet Medicaid eligibility requirements in effect before title XXI was enacted. This policy ensures that SCHIP funds will be used to cover only newly eligible children and not supplant funds already available through Medicaid to cover eligible children at the applicable Medicaid FMAP. This policy also ensures that children who are eligible for Medicaid benefits and cost-sharing protections receive the benefits and protections to which they are entitled. At the same time, Congress intended for children to be able to apply for, and obtain, health care insurance as quickly as possible, without lengthy delay. Requiring a formal denial by the State Medicaid agency in all cases would not promote the intent of the law. Permitting children who are found unlikely to be eligible for Medicaid through a screening process to proceed with their application under a separate child health program without a formal Medicaid determination be made, best balances these two goals.

Comment: Some commenters were concerned that States would make the Medicaid application process difficult and unfriendly while making the

application for a separate child health program simple so that families would choose to apply for the separate program but not Medicaid, and that the State would get the enhanced Federal match. One commenter particularly supported the policy that refusal to apply for Medicaid affects eligibility for a separate child health program. A number of other commenters objected to the policy of denying eligibility for a separate program when a child is found potentially eligible for Medicaid but the family makes an informed choice not to apply for Medicaid or chooses not to complete the Medicaid application process. One commenter argued that this policy goes beyond statutory authority. Most of those objecting to the policy expressed concern that it would result in children going without health coverage at all.

Response: How well the screening process works depends in large part on State Medicaid application rules and procedures. States have broad discretion under federal law to simplify and streamline their enrollment processes. We encourage States to simplify the Medicaid application process and to make the division between separate child health programs and Medicaid appear seamless, and many States have done so.

While we recognize that some families may decide to go without insurance rather than apply for Medicaid, we believe that it would be contrary to the statutory purposes to permit States to enroll children in a separate child health program who have been found potentially eligible for Medicaid through a screening process. As many States have demonstrated, States have the flexibility to address most, if not all, of the reasons why families might prefer not to apply for Medicaid. If families are reluctant to apply for Medicaid, the State may need to reexamine the Medicaid application and redetermination process, as well as its outreach and marketing strategies, to assess how barriers to participation can be eliminated. For example, States have shown that families are more likely to complete the Medicaid application process if face-to-face interviews are eliminated, resource tests for children are dropped and documentation requirements are reduced. If a joint application process and a single program name are used, the procedures can be made seamless and the difference between separate child health programs and Medicaid made almost invisible to the family. States are continuing to experiment with different ways to promote seamless enrollment and coverage systems.

HCFA will be focusing considerable attention over the coming months on ways to help States develop seamless, family-friendly application and eligibility determination systems and to promote best practices across States. These practices will not only help States meet the screen and enroll requirements, but also will help States identify and enroll the millions of uninsured children who are eligible for, but not enrolled in, Medicaid.

Comment: Many of those commenting on the screening requirements were concerned that not all children who are eligible for Medicaid will be identified. A number of commenters disagreed with the policy that the screening process only needs to screen for eligibility under the children's poverty level groups described in 1902(l). Quite a few were concerned that children with special needs who might qualify for Medicaid under another eligibility group will end up enrolled in a separate child health program that may provide less coverage than Medicaid. Some urged HCFA to require that States ask whether a child is disabled or has special needs. Others disagreed with the statement in the preamble that requiring States to screen for eligibility under all possible groups would place an unreasonable administrative burden on States. These commenters pointed out that States have considerable flexibility to simplify eligibility under Medicaid, particularly under section 1931.

One commenter noted that screening and determining eligibility are not the same. This commenter suggested that it is quite feasible to devise a simple, short list of questions to screen for eligibility in non-poverty related groups, and that the regulations should require that States screen considering the most liberal income eligibility standard for the child given the child's age, disability and the family's prior eligibility for § 1931. One commenter suggested that States be required to screen for eligibility for children under sections 1931 and 4913 of the Balanced Budget Act of 1997. Four others suggested that the regulations should require States to screen considering the highest effective income threshold, taking income disregards into account.

One commenter expressed concern about the extent to which income exclusions and disregards must be applied in the screening process. This commenter suggested that the screening should include only the standard deductions applicable to all poverty-level Medicaid eligibility groups. Another commenter stated that requiring independent entities to be knowledgeable about income exclusions under other Federal statutes, particularly those which are not likely to be encountered, is contrary to simplification.

Finally, one commenter was concerned that a pregnant teen who could be eligible for Medicaid as a pregnant woman might be found ineligible for both a separate child health program and Medicaid if the screening process did not include a method of identifying pregnant teens.

Response: We have tried to balance the statutory screen and enroll requirements with the requirement that child health benefits be provided in an ''effective and efficient manner,'' taking into consideration the fact that screening may be done by entities that may not be familiar with the intricacies of Medicaid eligibility. For this reason, we have not required a full Medicaid application or a formal decision on such an application before a child can be eligible for a separate child health program.

We have, however, reevaluated our position on screening for eligibility under section 1931 of the Act in light of the fact that in some States the highest eligibility threshold for non-disabled children is applied through the § 1931 eligibility group. We also recognize that some States expanded Medicaid eligibility through the authority of section 1115 of the Act, resulting in a higher eligibility threshold for some children. We have revised § 457.350(b) (proposed § 457.350(c)) to require that a State that has used the flexibility provided under § 1931 to expand eligibility must screen for eligibility under one of the poverty level groups described in section 1902(l), section 1931 of the Act, or a Medicaid demonstration project under section 1115 of the Act, whichever standard generally results in a higher income eligibility level.

States that have expanded eligibility under section 1931 beyond the poverty level category generally have adopted similar income eligibility rules; at a minimum, the section 1931 income methodologies are not likely to be significantly more complicated than the poverty level rules. Further, States need not screen families under both section 1931 and section 1902(l). Rather, they must screen under whichever methodology generally results in a higher income eligibility level for the age group of the child applying for assistance.

Because we are requiring States to screen under whichever methodology generally results in a higher income eligibility level, States do not have to apply every income and resource disregard used under its State plan.

Disregards that apply only in very limited circumstances need not be routinely used in the screening process. For example, many families applying for coverage under section 1931 would be expected to have earned income, so earned-income disregards must be applied in the screening process. However, few applicant families would be expected to have income-producing property. Thus, a State that disregards such income under section 1931 would not have to apply this disregard in the screening process.

We had included proposed § 457.350(c)(2) in the proposed rule to ensure that the children eligible for Medicaid under section 1902(a)(10)(A)(ii)(I) (the ''Ribicoff children'') would not be missed in the screening process. However, most of these children will be identified under the revised § 457.350(b). Therefore, cognizant of the need to keep the screening process as simple as possible, we have removed proposed § 457.350(c)(2) from the final regulation.

We share the commenters' concern about children with disabilities being left out of the screening process and strongly encourage States to screen for children who might be eligible for Medicaid on the basis of disability. Questions about a child's potential disability may be included on the separate child health or joint SCHIP/Medicaid application for follow-up. We require States to ensure that parents are provided with information about all Medicaid eligibility categories and coverage, are encouraged to apply for Medicaid under other eligibility categories and are offered assistance in applying for Medicaid. However, we do not agree with the comment that a child should be denied coverage under a separate child health program unless a full Medicaid disability determination has been made. The definition of disability for Medicaid purposes is not easily understood by people unfamiliar with Medicaid eligibility rules, and screening for eligibility based on disability could be very time-consuming. We note that States have 90 days, rather than 45, to determine Medicaid eligibility when disability is involved. Moreover, particularly in light of recent State Medicaid expansions, most children who would be eligible for Medicaid on the basis of disability will also meet the eligibility requirements as a poverty level child.

We also do not specifically require States to screen for eligibility under section 4913 of the BBA. The State is responsible for ensuring that disabled children who lost SSI because of the change in the definition of childhood disability (''section 4913 children'') are aware of their right to Medicaid benefits. States must identify and provide coverage for section 4913 children, but it is highly unlikely that a child who would be eligible as a section 4913 child would not be identified in the screening process as potentially Medicaid eligible on the basis of his/her income alone. In any event, Medicaid confidentiality rules do not allow States to provide lists of section 4913 children to entities that determine eligibility for a separate child health program but that do not also determine Medicaid eligibility.

Comment: One commenter pointed out that a screening based on income alone would be insufficient in a State that continues to apply a resource test to children under Medicaid. They recommended that § 457.350 be revised to clarify that, in such situations, States must evaluate whether children meet both income and resource tests for Medicaid eligibility.

Response: We agree that, in States that continue to apply a resource test to children under Medicaid, when an income screen indicates that a child is potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility under the applicable Medicaid resource test. A resource screen limits those cases in which a child is found potentially eligible for Medicaid based on an income test, but is then reviewed under Medicaid rules and found ineligible based on resources (and is then sent back to the separate child health program for another eligibility review). We have added a new paragraph (d) to § 457.350 to include this requirement. If a State continues to apply a resource test for children under the eligibility groups described in § 457.350(b) (§ 457.350(c) in the proposed rule) and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing the family's countable resources to the appropriate Medicaid resource standard. In conducting the screening, the State must apply Medicaid policies related to resource requirements, including policies related to resource exclusions and disregards and policies related to resources for particular Medicaid eligibility groups. However, in an effort to balance the statutory mandate that children eligible for Medicaid not be enrolled in a separate child health program with the need to keep the screening process as simple as possible, States need not take into account disregards that apply only in very limited circumstances in the screening process. Any resource exclusions and disregards which the State does not plan to use in the screening process must be identified in the State plan.

Since most States no longer apply a resource test to children, this added screening requirement will not affect most States. State experience indicates that children who are income eligible seldom have resources in excess of the resource standard previously used, with the possible exception of a car that is usually needed for transportation to and from work. States have found that requiring information about resources that are highly unlikely to make a child ineligible, or that rarely provide a family with a greater ability to purchase health coverage, is an unnecessary administrative burden, a barrier to eligibility, and helps to reinforce the ''welfare stigma.'' HCFA encourages the few States with resource requirements for children to eliminate or otherwise simplify any remaining resource tests under both Medicaid and separate child health programs. However, any State that retains a resource test for Medicaid must screen all applicants who appear income-eligible for Medicaid for eligibility under the applicable resource test.

Comment: One commenter indicated that screening is particularly difficult when an employer-sponsored model is used for SCHIP. This commenter suggested that States be given the option to accept a lower Federal match, for example, the Medicaid match, in lieu of meeting the Medicaid screen and enroll requirements.

Response: We do not have the statutory authority to provide a lower match in lieu of meeting the Medicaid screen and enroll requirements. Furthermore, because eligibility determinations are distinct from determinations about the kind of coverage an eligible child will receive, there does not seem to be any reason why the screen and enroll requirements would present any particular problems for States with premium assistance programs. States are required to screen all children applying for coverage under a separate child health program.

Comment: We received a significant number of comments concerning the requirement that certain information about Medicaid be provided to families if a State uses a screening procedure other than a full determination of Medicaid eligibility. Many commented that this requirement is administratively burdensome, a waste of administrative resources, exceeds statutory authority, and is contrary to the purpose and goal of the separate child health program option provided by Congress. Some

commenters believed that this requirement would mean that a full Medicaid determination needs to be made in every case. Others were concerned that it would be confusing to families whose children were found eligible for a separate child health program, would slow down the eligibility determination process, and would create a barrier to access in situations where the family did not want Medicaid. Several commenters stated that there is no evidence that Medicaid-eligible children are being missed in the screening process and that to the contrary, State-based evidence suggests that many more such children are being found than anticipated.

Other commenters did not think that the notice requirements went far enough and they urged HCFA to require that the information provided describe disability-based, medically-needy and § 1925 transitional Medicaid eligibility. One commenter recommended that proposed § 457.350(f)(1) be revised to read ''based on limited review, we could not tell if your child is eligible for Medicaid.'' Another recommended adding ''and orally in a manner that is literacy and language appropriate'' to the lead-in to the required list of notifications. One commenter recommended that the final rule include an example of notice language to be sent to children who are determined unlikely to be Medicaid-eligible as a result of a limited screening process. Several others questioned whether the cost of providing the information about Medicaid would be an SCHIP administrative cost subject to the 10 percent cap on administrative expenses.

Response: Providing information about Medicaid will not necessarily create a barrier to enrollment. Families are entitled to have complete information on which to base a decision about applying for coverage. We are pleased that reports from many States indicate that many Medicaid-eligible children are being found through the screening process. However, the results across all States are not uniform and there is no way to know how many other Medicaid-eligible children are not being identified. Because all families are entitled to have information on their child's eligibility for coverage, we are retaining this provision with clarification.

We agree that families need to understand that no formal determination of the child's Medicaid eligibility has been made, nor has the child been screened under all Medicaid eligibility categories. We note that a Medicaid determination does not need to be made in every case, but rather only for those children screened as potentially eligible for Medicaid using the joint application, and that a Medicaid eligibility determination can only be issued by the State agency designated to make the determination. In the instance where the same agency that makes the Medicaid determination of eligibility also determines eligibility for the separate child health program, a determination of Medicaid eligibility must be issued, in addition to the notice required at § 457.350(e).

We have clarified the language of proposed § 457.350(f) at § 457.350(g)(1) of this final rule to provide that the State must inform the family, in writing, that based on a limited review, the child does not appear to be eligible for Medicaid, but that Medicaid eligibility can only be determined from a full review of a Medicaid application under all Medicaid eligibility groups. We have not included actual or proposed notice language in the final rule. Due to the differences in Medicaid programs, the language necessarily will vary from State to State. However, we are working to identify good notice language and best practices and will disseminate this material to States.

We expect that the information will be comprehensive and include information about Medicaid eligibility based on disability, pregnancy, excessive medical expenses, or unemployment of the family wage earner. We also expect that this information will be provided in a simple and straightforward manner that can be understood by the average applicant and that meets all applicable civil rights requirements, including the Americans with Disabilities Act (ADA). The information can be provided along with other information conveyed to SCHIP applicants or it can be a separate notice. The cost of providing information about Medicaid eligibility need not be a SCHIP administrative expense subject to the 10 percent cap. A State may choose to charge the cost of providing information about Medicaid as an administrative expense under title XIX.

Comment: A few commenters indicated that the regulations should make it clear that a child can be enrolled in a separate child health program while undertaking the full Medicaid application process. Other commenters recommended enrolling a child in a separate child health program for 45 days to allow processing of the Medicaid application.

Response: As discussed above, at its option, a State may provisionally enroll or retain current enrollment of a child who has been found potentially eligible for Medicaid in a separate child health program, for a limited period of time, as specified by the State, pending a final eligibility decision. However, the child cannot be ''eligible'' for the separate program unless a Medicaid application is completed and a determination made that the child is not eligible for Medicaid.

As noted above, we have revised our policy based on the recent enactment of BIPA to permit health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and § 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with § 435.1101 to no longer be constrained by the 10 percent cap.

Comment: We received several comments urging HCFA to emphasize opportunities for simplifying the screen and enroll process and making the process ''family-friendly.'' Among the suggestions were: using a joint application or a single State agency; avoiding confusing options for families to opt in or out of Medicaid; eliminating age-based rules; adopting the same verification requirements as Medicaid; adopting the same income and resource methodologies as Medicaid; eliminating documentation requirements in Medicaid that are not required by the separate child health program; and requiring that any simplifications in the application process that States adopt for Medicaid or a separate child health program not be denied to children whose families also happen to be TANF or Food Stamp applicants or recipients.

Response: The suggested simplifications are ways in which confusing options and complex procedures can be eliminated and the screen and enroll process be made ''family-friendly.'' We encourage States to adopt these simplifications. As States experiment with new ways to coordinate their child health coverage programs, they are finding that alignment of program rules and procedures can greatly simplify the task of coordinating enrollment. As for children who are also applying for, or are receiving, Food Stamps or TANF, we emphasize that, while States may use joint child health, Medicaid, Food Stamp and TANF applications, they cannot condition Medicaid eligibility on Food Stamp or TANF requirements that

do not apply to Medicaid. For example, if a State Medicaid program does not require a face-to-face interview to determine a child's eligibility for Medicaid, a child applying for Medicaid and Food Stamps on a joint application cannot be denied Medicaid simply because the child's family does not comply with the Food Stamp interview requirement. Similarly, States cannot condition eligibility for a separate child health program on Food Stamp or TANF requirements that do not apply to that program.

Comment: Many of those who commented on the screen and enroll process were concerned generally about families ''falling through the cracks'' because of the back and forth between separate child health programs and Medicaid or going without any health care for a period of time because of the process requirements. One commenter was particularly concerned about children leaving State custody from foster care or the juvenile justice system, who are at great risk of failing to apply for health coverage after they leave State custody. A significant number suggested that the regulations provide that a State cannot require a child to reapply for a separate child health program if the child is screened potentially eligible for Medicaid, but later determined ineligible for Medicaid. Most suggested that the separate child health program application should be suspended or provisionally denied when a child is found to be potentially eligible for Medicaid, pending a final Medicaid eligibility determination.

Other commenters found the distinction between joint and separate applications confusing with respect to the screening requirements. The commenters requested clarification as to whether the procedures for use of joint applications also apply to separate child health programs.

Response: There are many policies and procedures that States with separate child health programs can adopt to ensure that children do not ''fall through the cracks.'' When a child is identified through screening as potentially eligible for Medicaid, States may suspend, deny or provisionally deny the separate child health application. Alternatively, if the State has established a presumptive eligibility process for a separate child health program, the State may enroll an applicant in the separate child health program pending the formal determination of Medicaid eligibility; we have added a new section § 457.355 to reflect this option. It should also be noted that we have revised our policy to allow health coverage expenditures for children during the presumptive eligibility period to be treated as health coverage for targeted low-income children whether or not the child is ultimately found eligible for the separate child health program, as long as the State implements presumptive eligibility in accordance with section 1920A and section 435.1101 of this part. This preserves State flexibility to design presumptive eligibility procedures and allows States that adopt the presumptive eligibility option in accordance with section 435.1101 to no longer be constrained by the 10 percent cap.

We also have clarified the regulations at § 457.350(f)(5) (§ 457.350(e)(2) in the proposed regulations) to require that, if a child screened potentially eligible for Medicaid is ultimately determined not to be eligible for Medicaid, once the State agency or contractor that determines eligibility for the separate child health program has knowledge of the Medicaid determination, the child's original application for the separate child health program must be reopened or reactivated and his/her eligibility under the separate child health program determined without a new application. We believe that most States currently follow this procedure to ensure that the screening process does not improperly deny coverage under the separate child health program.

As discussed below, we have also added a rule directed to the Medicaid agency that requires that agency to promptly inform the SCHIP agency or contractor when a child who has been screened as potentially eligible for Medicaid is found ineligible for Medicaid (see section 431.636 of this chapter).

We have clarified § 457.350(f)(1) (§ 457.350(e)(1) in the proposed rules) to indicate that a State may suspend, provisionally deny or deny the application of a child screened potentially eligible for Medicaid. (Note that to provisionally deny an application is the same as finding the child provisionally ineligible for the separate child health program.) Putting the application into suspense for a reasonable period of time before taking action on it would preserve the child's initial application date and ensure follow-up on the part of the State agency or contractor after the specified time period had elapsed or the agency or contractor learned that the child has been determined ineligible for Medicaid, whichever is sooner. If a State provisionally denies the application and the child is subsequently determined ineligible for Medicaid, the child's initial application would be reactivated as soon as the State agency or contractor that determines eligibility for the separate child health program learns of the denial of Medicaid eligibility. In either case, the family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility).

In most circumstances, no further action on the part of the family will be necessary to reactivate or reopen the application for the separate child health program following a denial of Medicaid eligibility. For example, in States in which the State Medicaid agency also determines eligibility for the separate child health program, no further action on the part of the family will be required. Similarly, States that use a joint application and that closely coordinate the eligibility determination process (for example, through electronic transfers or by co-locating eligibility workers) can ensure that Medicaid determinations for children identified as potentially Medicaid-eligible can be made quickly and that the decision (and underlying information) can also be conveyed quickly back to the workers responsible for determining eligibility for the separate program.

We agree that the screening requirements are the same whether a joint application or separate applications are used, although the procedures States will need to adopt to meet these requirements will vary depending on whether a joint application is used. Therefore, we have deleted proposed § 457.350(b) to eliminate confusion. All States, including those that use a joint application, are required to meet the screening requirements in § 457.350.

We have added a new subparagraph § 457.350(f) to clarify the State's responsibilities for ensuring that the Medicaid application process for a child screened potentially eligible for Medicaid is initiated and, if eligible, that the child is enrolled in Medicaid, as required by section 2102(b)(3)(B) of the Act.

In general, in States that use a joint application, the State agency or contractor that conducts the screening shall promptly transmit the application and all relevant documentation to the appropriate Medicaid office or Medicaid staff to make the Medicaid eligibility determination, in accordance with the requirements of § 431.636, a new provision which sets forth the Medicaid agency's responsibilities with respect to the screen and enroll requirements of title XXI. Because the agency administering the separate child health program may not be the agency

authorized to make Medicaid determinations in the State, it is at the point when the joint application form is transmitted to the Medicaid office from the separate program that it becomes a Medicaid application. We have added the definition of ''joint application'' at § 457.301 to clarify this point and to facilitate the processing of joint applications. Specifically, we define a joint application as a form used to apply for a separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid. We encourage States that use a separate application for a separate child health program to design their applications so that families can easily waive confidentiality under SCHIP to allow the agency or contractor that conducts the screening to transfer information to the Medicaid agency when a child has been found potentially eligible for Medicaid.

In States which do not use a joint application for Medicaid and separate child health programs, the State agency or contractor that conducts the screening shall (1) inform the applicant that the child is potentially eligible for Medicaid; (2) provide the applicant with a Medicaid application and offer assistance in completing the application, including providing information about what, if any further information and/or documentation is needed to complete the Medicaid application process; and (3)promptly transmit the application and all other relevant information, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid eligibility, in accordance with § 431.636.

It should be noted that under most circumstances, the term ''promptly'' means that the entire process (including screening and facilitation between SCHIP and Medicaid) for determining eligibility should be completed within the 45 day period. However, we recognize that there are cases where the timing of the process is beyond the control of the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the family's income has changed, making them eligible for the separate child health program, we understand that the need to transfer paperwork back and forth between programs can take additional time beyond the 45 days.

Alternatively, under § 457.350(f), the State can establish other procedures to eliminate duplicative requests for information and documentation and ensure that the applications and all relevant documents of children screened potentially eligible for Medicaid are transmitted to the Medicaid agency or staff and that, if eligible, such children are enrolled in Medicaid in a timely manner.

We also have added a section § 457.353(a) to require that States monitor and establish a mechanism to evaluate (1) the process established in accordance with § 457.350 to ensure that children who are screened potentially eligible for Medicaid apply for and, if eligible, enroll in that program and (2) the process established to ensure that the applications for a separate program of children who are screened potentially eligible, but ultimately determined by the Medicaid agency not to be eligible, for Medicaid are processed in accordance with § 457.340 of this subpart.

Data collection will need to be a part of any mechanism developed to effectively evaluate the screen and enroll process. For example, States will need to collect data on the number and percent of children applying for a separate child health program who are screened potentially eligible for Medicaid; the number of those screened potentially eligible for Medicaid who ultimately are determined to be eligible versus the number determined not to be eligible for Medicaid; the number of those children ultimately determined not to be eligible for Medicaid whose applications for the separate child health program are processed; etc. These data will help States and HCFA evaluate whether the procedures States adopt are accomplishing the goal of enrolling children in the appropriate program or whether modifications are needed.

We have modified the language in § 457.350(f)(5)(ii) to clarify that States must determine or redetermine the eligibility of a child initially screened eligible for Medicaid if the child's circumstances change and under § 457.350(e) another screening shows that the child does not appear to be eligible for Medicaid. We have added the phrase ''does not appear to be'' to reflect the fact that only the State Medicaid agency is authorized to actually determine that a child is ineligible for Medicaid. Contractors can only make a determination as to the likelihood of the child's eligibility for purposes of proceeding with the application for a separate child health program.

Second, we have added a new subparagraph at § 457.350(f)(5)(iii) to clarify that, in determining or redetermining the eligibility for a separate child health program of a child screened potentially eligible, but ultimately determined not eligible, for Medicaid, the child may not be required to complete a new application, although it may supplement the information on the initial application to account for any changes in the child's circumstances or other factors that may affect eligibility.

We also have added a new subsection § 457.350(h) to require that States which have instituted a waiting list for the separate child health program develop procedures to ensure that the screen and enroll procedures set forth in § 457.350 have been complied with before a child is placed on the waiting list. This ensures that children who are eligible for Medicaid are not placed on a waiting list if a State has closed enrollment for its separate child health program. These requirements ensure that eligible children are enrolled in the appropriate program without delay and without unnecessary paperwork barriers. At the same time, they give States ample leeway to design the system that works best for them. No one system is prescribed, but States will need to monitor and evaluate how well their system is working, and they will be held accountable for ensuring that the system they have designed and implemented complies with the statutory and regulatory requirements.

Comment: We received one comment that the regulations should clearly indicate that a State may cease accepting applications for its separate child health program when enrollment is closed.

Response: The State may stop accepting applications as one method of administering an enrollment cap. If the State is using a joint application, which is also an application for Medicaid, then the State must have provisions to assure that the Medicaid eligibility determination process is initiated, even if enrollment in the separate child health program has been suspended. If, after a State plan that does not authorize an enrollment cap is approved by HCFA, the State opts to restrict eligibility by discontinuing enrollment, the State must submit a State plan amendment in accordance with §§ 457.60 and 457.65 of this final rule.

Comment: Two commenters suggested that the preamble reiterate that a child who must meet a spend down does not have ''other coverage'' and may be eligible for the separate child health program.

Response: We have not required States to screen for Medicaid eligibility under the medically needy groups described in section 1902(a)(10)(C) of the Act because of the uncertainty inherent in determining whether and

when a spend down has been met. A child who is not yet ''medically needy'' because he or she has not yet met the spend down requirements is not considered to be eligible for Medicaid for purposes of the screening requirement. However, an individual who could be eligible for Medicaid as medically needy with a spend down has a right to apply for Medicaid, and should be informed of the spend down category. If a child is eligible without a spend down or if it is determined that the spend down has been met, then the child would be eligible for Medicaid and would not be eligible for the separate child health program. Information about the State's medically needy program must be included in the information provided to applicants for a separate child health program.

Comment: In response to our request for comments on the extent of the Medicaid ''stigma'' problem and possible solutions, several commenters noted that poor coordination between separate child health programs and Medicaid expansions contributes to the stigmatization of Medicaid. One commenter noted that many working people take pride in their achievements and posited that they prefer to pay their own way rather than participate in what they perceive as a public assistance program. This commenter felt that people's desire for self-reliance is not an attitude that public policy can (or should) change.

According to the commenters, a program is more likely to be successful in insuring children if these attitudes are taken into account. Two commenters said that negative reactions to Medicaid are due to its historic association with welfare; discourteous or intrusive treatment by workers; difficult application processes; negative treatment by providers; negative personal experiences and those of friends and neighbors.

Several commenters suggested that the stigma can be alleviated by having a simple, joint enrollment process and creating a seamless environment. One commenter suggested that a non-public entity be allowed to enroll children in Medicaid. Another recommended that HCFA encourage States to offer applicants a choice of settings in which to be enrolled, because reliance on a public monopoly reinforces the stigma. Additional suggestions included giving both programs one name; adopting a joint application; eliminating asset tests; encouraging presumptive eligibility; expanding outreach and enrollment sites; eliminating face-to-face requirements; and offering a single application site. One commenter also recommended that HCFA continue to research best practices and promote them.

One commenter suggested that ensuring that providers in both programs are paid adequately and that provider networks in both programs provide convenient access to high quality services is a critical step as well. We received one suggestion that HCFA assess the barriers to Medicaid enrollment in each State and develop and implement a State-specific plan to address and remove such barriers. Several commenters asserted that the situation is difficult to resolve given the current statutory requirements and suggested that HCFA fund a study and make suggestions for legislative changes.

Response: We appreciate the responses on the stigma issue and have incorporated many of them in our guidance and suggestions to the States. We will continue to research and promote best practices and note that many States have successfully eliminated or greatly limited the welfare stigma which sometimes is associated with Medicaid and have converted Medicaid to a program that operates as, and is perceived to be, a health insurance program.

We encourage States to continue to simplify their processes and eliminate barriers to facilitate enrollment and retention among eligible individuals. We also encourage States to employ outreach efforts geared toward changing the perception that Medicaid is ''welfare.'' We urge States to make clear in all their informational materials about the TANF cash assistance program that coverage under Medicaid or a separate child health program is not linked to TANF eligibility or enrollment and that, whether or not families apply for or receive TANF assistance, they are encouraged to apply for Medicaid and any separate child health program.

8. Facilitating Medicaid Enrollment(§ 457.360)

Under section 2102(b)(3)(B) of the Act, States are required to ensure that children found through the screening process described above to be eligible for Medicaid apply for and are actually enrolled in Medicaid. We proposed in § 457.360(a) that the State plan must describe the reasonable procedures to be adopted to ensure that children found through the screening to be potentially eligible for Medicaid actually apply for and are enrolled in Medicaid, if eligible. Under proposed § 457.360(b), States must establish a process to initiate the Medicaid enrollment process for potentially Medicaid eligible children and several options for States are provided.

We also proposed to require at § 457.360(c) that a State ensure that families have an opportunity to make an informed decision about whether to complete the Medicaid application process by providing full and complete information, in writing, about (1) the State's Medicaid program, including the benefits covered and restrictions on cost-sharing; and (2) the effect on eligibility for coverage under the separate child health program of neither applying for Medicaid nor completing the Medicaid application process.

Comment: We received one comment that States should not be required to ''ensure'' that children enroll in Medicaid because States cannot dictate to families, but can only assist them.

Response: The statute specifically requires that States ''ensure'' that children are enrolled. It is correct that a family cannot be forced to apply for Medicaid and that States cannot ultimately ''ensure'' that an eligible child is enrolled. However, it is the responsibility of the State to remove barriers to enrollment, adopt procedures that promote enrollment of eligible children, and ensure that the family understands the benefits of Medicaid and the consequences of not applying for Medicaid.

Comment: We received a number of comments pertaining to the information about Medicaid which must be provided to families. One commenter stated that it was not reasonable to expect States to ''ensure'' that a family's decision not to apply for Medicaid is an informed decision and that this could lead to costly litigation over whether the State has taken sufficient measures. A significant number of commenters were concerned that States would be required to provide ''reams'' of in-depth information about Medicaid and commented that general information ordinarily provided to any family interested in applying for Medicaid should be sufficient. Finally, one commenter recommended that information about the benefits of Medicaid be provided to adolescents in a format and language that can be easily understood by both the adolescent and the family.

Response: Sufficient information must be provided to families to enable them to make an informed decision about completing an application for Medicaid. We agree that information about Medicaid eligibility and the benefits of Medicaid should also be in a format that adolescents can understand as appropriate. We also note that the provision of information to families

under proposed § 457.360(c), section § 457.350(g) of the final rule, only applies for States that use a separate application for their separate child health plan and those using a joint application which permits families to check a box on the application to elect not to apply for Medicaid.

In some cases, the general information provided ordinarily to any family interested in applying for Medicaid may provide sufficient information about Medicaid itself for these purposes. However, the State must also inform the family about the effect on eligibility for the separate child health program if the family chooses not to apply for Medicaid or not to complete the Medicaid application process, as many families will not realize that they do not have a choice between programs.

We have reconsidered the use of the term ''ensure'' because we agree that States cannot ''ensure'' that a decision is an informed one, no matter how much or how understandable the available information. States can only make the information available in an accessible way. We have revised the regulation at new § 457.350(g) (proposed § 457.360(c)) to require that States provide sufficient information to enable the family to make an informed decision.

Comment: One commenter suggested that, because Medicaid eligibility may result in automatic referral to CSE, States should inform families applying for the separate child health program about the rights and responsibilities associated with being found eligible for Medicaid, including the assignment of medical support rights and the right to claim an exemption from the cooperation requirements. The commenter is concerned that a mother applying for SCHIP, where there is no need for contact with the noncustodial parent, may not mention that she has been subject to domestic abuse at the time of applying, and might be automatically referred to CSE when there is good cause for not being referred.

Response: A Medicaid application for a child should not result in a referral to the CSE agency absent the cooperation of a parent. We agree that whenever a Medicaid or separate child health program application is filed, the family should be informed about the services offered by the CSE, its opportunity to take advantage of these services, and whether additional information will be required. Cooperation with establishing paternity and pursuing medical support is *not* a condition of a child's eligibility for Medicaid. Parents can be asked whether they would like to pursue medical support through CSE, but a cooperation in obtaining CSE cannot be required as a condition of a child's eligibility for Medicaid. If a parent also is applying for Medicaid, the parent should be informed of the acceptable reasons for refusing to cooperate and of the distinct consequences for the parent's and child's eligibility of not cooperating if none of the acceptable reasons applies.

Comment: One commenter noted that States should be given flexibility in the areas of application and enrollment. Another commented that the proposed regulations are overly prescriptive and exceed statutory authority by requiring States and SCHIP applicants to go through a tedious and administratively difficult process of obtaining a written waiver from applicants stating they do not wish to apply for Medicaid or complete a Medicaid application as required in proposed § 457.360(c).

Response: As discussed in the responses to several comments below, States have a great deal of flexibility in the areas of application and enrollment. There is no requirement that SCHIP programs ask families for a waiver; in fact, under title XXI, States do not have the option of enrolling children in the separate program if a Medicaid screen indicated the child may be eligible for Medicaid, even if a family waived their right to apply for Medicaid. States must inform families about the consequences for the child's coverage of not applying for Medicaid and develop systems to facilitate seamless enrollment in Medicaid for eligible children pursuant to § 457.350. Under § 457.350(f)(1), the State could suspend the child's application for the separate program unless or until a completed Medicaid application for that child is denied. This would preserve the child's initial application date and ensure follow-up on the part of the State SCHIP agency after the specified time period had elapsed.

Alternatively, a State may deny, or provisionally deny, the separate child health program application. As discussed earlier, if a State provisionally denies the application and the child is subsequently determined ineligible for Medicaid, the child's initial separate child health program application should be reactivated as soon as the SCHIP agency learns of the denial of Medicaid eligibility. The family would not need to provide any additional information (unless there has been a change in circumstances that could affect eligibility). If the child chooses not to apply for Medicaid, the denial or provisional denial under a separate child health program will stand (unless the child's circumstances change and a new screen shows that the child no longer appears potentially eligible for Medicaid).

Comment: Several commenters were concerned that the application process for Medicaid would be a barrier to enrollment in a separate child health program. Some expressed concern that the proposed rule would fail to prevent States from using unnecessary administrative barriers and hostile or adversarial treatment by Medicaid eligibility workers as a means of discouraging families from successfully completing a Medicaid application and one urged HCFA to prevent States from requiring that applicants screened potentially Medicaid-eligible go through complicated, time-consuming and demeaning processes. Two recommended that HCFA prohibit States from making the process for applying for Medicaid more burdensome, onerous or time-consuming than the process for applying for a separate child health program. A few urged that the screen and enroll requirements be enforced, monitored, and evaluated to ensure that all children eligible for Medicaid are reached. One of the commenters urged HCFA to set high standards to ensure that States actually enroll screened children in Medicaid.

Response: Section 2102(b)(3)(B) of the Act requires States to describe in their State plan their procedures for ensuring that children screened potentially eligible for medical assistance under the State Medicaid plan under title XIX are enrolled in Medicaid. We have implemented that statutory provision at § 457.350(a)(1). A simple referral to the Medicaid agency is not enough to meet this requirement. In § 457.350, we require that States take reasonable action to facilitate the Medicaid application process and to promote enrollment of eligible children into Medicaid.

We do not have the statutory authority to require any particular application process, or that the Medicaid application process be no more difficult than the application procedures for separate child health programs. However, we appreciate the commenters' concerns and encourage States to examine their administrative systems and to simplify and minimize barriers in their application and enrollment processes for both Medicaid and separate child health programs to the extent possible. We are pleased that most States are moving in this direction and will continue to provide technical assistance on this matter as needed.

Given Congressional concern that title XXI funds not be used to supplant existing health insurance coverage, ensuring compliance with the screen and enroll requirements of title XXI is a high priority for HCFA and will be strictly monitored, evaluated, and enforced. As previously discussed, we have added a new § 457.353(a) to require States to monitor and establish a mechanism to evaluate the processes adopted by the State to implement the screen and enroll provisions of § 457.350.

Comment: Two commenters recommended that States be required to send a notice after an initial screen finds potential Medicaid eligibility.

Response: The State needs to provide written notice of any determination of eligibility under § 457.340(d). If the State determines that an applicant is ineligible for coverage under its separate child health program, the State must provide written notice of that determination. In addition, under § 457.350(g) the State must provide families with information to enable them to make an informed decision about applying for Medicaid; and under § 457.350(f)(3), if a State does not use a joint application for Medicaid and its separate child health program, applicants that are screened potentially Medicaid-eligible must be given notice that they have been found potentially eligible for Medicaid, and be offered assistance in completing a Medicaid application (if necessary), and provided information about what is required to complete the Medicaid application process.

Comment: We received two comments related to the effective date of an application. One commenter requested that the regulations clarify that if a joint application is used, the date of the application for a separate child health program is also the date of application for Medicaid. One commenter believed that if an application for the separate child health program is denied, the State must provide notice to the applicant and must also continue to process the Medicaid application within the 45-day time frame.

Response: If a State uses a joint application for Medicaid and its separate child health program, the date of application for Medicaid may or may not be the same as the date of application for the separate program. As indicated earlier, this is because the State agency that determines eligibility for Medicaid may not be the same entity that determines eligibility for the separate program. In some cases, it may not be reasonable to hold the Medicaid agency responsible for determining eligibility within 45 days when it could not have initiated the determination process until the application was transmitted from the entity administering the separate child health program.

The SCHIP entity's responsibility in this case is to promptly transmit the application to the Medicaid agency immediately following the screen. Under most circumstances, the term ''promptly'' means that the entire process (including screening and facilitation between the separate child health program and Medicaid) should be completed within 45 days. However, we recognize that there are also circumstances where the timing of the process is beyond the control of the separate child health program and the separate child health program. For example, if the process for determining Medicaid eligibility after a screen reveals that the child's family income has changed, making them eligible for the separate child health program, we understand that the transfer back and forth between programs can take additional time.

If a State uses separate applications for its separate child health program and Medicaid, States can but are not required to establish the date the separate application was filed as the effective date of filing for Medicaid. States have flexibility under the Medicaid program to establish the effective date of a Medicaid application. The regulations at § 431.636 of this chapter do require that the SCHIP agency and the Medicaid agency coordinate to design and implement procedures that are developed to coordinate eligibility to ensure that eligible children are enrolled in the appropriate program in a timely manner.

Comment: Two commenters recommended that the regulations require that, even if a separate application is used for the separate child health program, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant is required to take any additional steps in order to apply for Medicaid, that the Medicaid agency inform the family of the steps it must take.

Response: As discussed above, under § 457.350(f)(3), States that use a separate application must provide an applicant screened potentially eligible for Medicaid with a Medicaid application; offer assistance in completing the application, including providing information about any additional information or documentation needed to complete the Medicaid application process; and send information and all relevant documentation obtained through the screening process to the appropriate Medicaid office or to Medicaid staff, to begin the Medicaid application process. An application for Medicaid would then be processed in accordance with Medicaid rules and regulations. Documentation (or photocopies) must be forwarded to the Medicaid agency along with other information wherever feasible. The family cannot be required to repeat information or provide documentation more than once. However, a separate child health application is not an application for Medicaid unless the State allows it to be used as such. Some States do use the separate child health program application as the Medicaid application when a child is screened as potentially eligible for Medicaid. This practice relieves the family and the State of the need to complete and review another application form.

As part of meeting their obligations under section 2102(b)(3)(B) of the Act, States must adopt reasonable procedures to ensure that a Medicaid application for children screened potentially eligible for Medicaid is completed and processed (provided that the family has not indicated that it does not wish to apply for Medicaid for the child). The obligations of the Medicaid agency in meeting this requirement are set forth in § 431.636 and discussed further in subpart M of this preamble, ''Expanded coverage of children under Medicaid and Medicaid coordination.''

Comment: A number of commenters suggested that the procedures in the regulations for facilitating Medicaid enrollment should specifically require that application assistance include bilingual workers, translators and language appropriate material or that the requirements of title VI and the ADA should be explained in the preamble. One commenter recommended that this include examples of how States and contracted entities can comply with these requirements.

Response: As required by § 457.130, the State plan must include an assurance that the State will comply with all applicable civil rights requirements. In addition, § 457.110 requires that States provide to potential applicants, applicants and enrollees information about the program that is linguistically appropriate and easily understood. Such materials and services, as well as compliance with the ADA, are required and important if

States are to effectively reach and enroll all groups of eligible children. We elected not to explain in detail all applicable civil rights requirements identified under § 457.130. However, interested parties can obtain additional information on these requirements by contacting the U.S. Health and Human Services' Office for Civil Rights.

9. Application for and Enrollment in a Separate Child Health Program § 457.340 (Proposed § 457.361)

Because we believe that the provisions of this section are closely related to those contained in proposed 457.340, in this final rule, we have incorporated the provisions of these two sections in the final regulation at § 457.340. However, we will respond to comments to proposed § 457.361 here.

In this section, we proposed to require that States afford individuals a reasonable opportunity to complete the application process and offer assistance in understanding and completing applications and in obtaining any required documentation. Furthermore, we proposed to require that States inform applicants, in writing and orally if appropriate, about the eligibility requirements and their rights and responsibilities under the program.

We noted in the preamble to the proposed rule that, although not specifically addressed in statute, a State may choose to provide a period of presumptive eligibility during which services are provided, although actual eligibility has not been established.

We proposed that the State must send each applicant a written notice of the decision on the child health application and that the State agency must establish time standards, not to exceed forty-five calendar days, for determining eligibility and inform the applicant of those standards. In applying the time standards, the State must count each calendar day from the day of application to the day the agency mails written notice of its decision to the applicant. We also proposed that the State agency must determine eligibility within the State-established standards except in unusual circumstances and that the State must specify in the State plan the method for determining the effective date of eligibility for a separate child health program.

In addition to the changes made in response to the comments discussed below, we have modified the language in § 457.361(c) (§ 457.340(d) in this final regulation) to clarify that States must notify families whenever a decision affecting a child's eligibility is made—whether the decision involves denial, termination or suspension of eligibility. In the case of a termination or suspension of eligibility, the State must provide sufficient notice, in accordance with § 457.1180, to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage of the child to continue without interruption. This clarification has been added in response to comments in order to ensure that children do not experience an unnecessary break in coverage because they have reached the end of an enrollment period.

Comment: Several commenters stated that HCFA should require States to notify the public of the priority standards, if any, for enrollment; inform individuals of their status on any waiting list; and maintain sufficient records to document that favoritism or discrimination does not occur in selecting individuals for enrollment.

Response: As discussed in the preamble to § 457.305, above, if a State plans to institute a waiting list or otherwise limit enrollment, it must include in its State plan a description of how the waiting list will be administered, including criteria for how priority on the list will be determined. In addition, § 457.110 requires States to inform applicants about their status on a waiting list.

Comment: We received several comments on the proposed requirement that a State determine eligibility under a separate child health program within 45 days. One commenter stated that the date of the application should not be the beginning of the 45 day period but rather the date that the application is received in the separate child health program eligibility office as there could be a delay for mailed-in applications. Another commented that the 45-day requirement does not take into account delays in obtaining necessary verifications from third parties such as employers or insurers. They suggested adding ''or other party with information needed to verify the application [delays * * *]'' or just requiring States to determine eligibility in a timely manner. A third supported establishing a 45-day time limit and prohibiting the use of time standards as a waiting period, but recommended that the regulations provide more specificity regarding when notice of rights and responsibilities must be given and a notice of decision provided. Another commenter felt that the 45-day requirement should be removed, that mirroring Medicaid is burdensome and costly, and allowing mail-in and drop-off applications may mean it will take longer to reach people to get all the necessary information.

Response: We have not changed the requirement in § 457.340(c) (proposed § 457.361(d)) that States must determine eligibility for a separate child health program within 45 calendar days (or less if the State has established a shorter period) from the date the application is filed. We have, however, clarified § 457.340(c)(2) (§ 457.361(d) in proposed rule) to require that States determine eligibility and issue a notice of decision promptly, but in any event not to exceed the time standards established by the State. This is consistent with the requirement that child health assistance be provided in an efficient manner, and that the 45-day period—or other time period specified by the State—may not be used as a waiting period. States have flexibility in deciding when an application is considered filed.

We agree that States should not be held responsible for delays caused by third parties beyond the State's control and have accommodated that concern in § 457.340(c)(2). We also have revised § 457.340(b) to specify that the notice of rights and responsibilities must be provided at the time of application. This ensures that families have the information they may need to proceed with the application process and successfully enroll their child.

Comment: We received two comments objecting to the requirement in § 457.340(a) that States assist families in obtaining documentation. They commented that States are not in a position to do this and that the requirement has the potential for enormous administrative burden.

Response: We will not be removing the phrase from the regulation, but will offer clarification related to this provision as we think the commenter may have misinterpreted the proposed rule. We expect that, in offering application assistance, the State or contractor for the separate child health program will provide assistance to applicants in understanding what documentation is needed to complete their applications and, to the extent possible, will assist applicants in determining where they might obtain the needed information. For example, if the State's application process requires verification of income and the applicant does not understand how they can prove their income, we would expect the State or the individual providing application assistance to be able to inform the family of the type of documentation (*e.g.,* pay stubs or W–2 forms) needed and where the applicant might be able to obtain that information (*e.g.,* from their employer). We do not expect a State to literally perform the

task of obtaining the documentation for the applicant, unless it so chooses or the document is readily available to it, and agree with the commenters that such a requirement would be administratively burdensome. Most States have produced application materials and program brochures and operate telephone help lines that provide the type of assistance required by the regulation.

10. Eligibility and Income Verification (§ 457.360)

In this final regulation, we have moved two provisions of proposed § 457.970, concerning eligibility and income verification, to new § 457.360. In proposed § 457.970, we proposed to require that States have in place procedures designed to ensure the integrity of the eligibility determination process, and to abide by verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations.

We proposed that States have flexibility to determine these documentation and verification requirements. In the preamble, we encouraged States to adopt procedures that ensure accountability while permitting self-declaration to minimize barriers in the application and enrollment process.

We also noted at § 457.970(c) that States with separate child health programs may choose to use the Medicaid income and eligibility verification system (IEVS) for income and resources, although they are not required to do so.

Finally, in § 457.970(d) we proposed to allow States to terminate the eligibility of an enrollee for ''good cause'' (in addition to terminating eligibility because the enrollee no longer meets the eligibility requirements)—*e.g.,* providing false information affecting eligibility. Under the proposed regulations, the State would have to give such enrollees written notice setting forth the reasons for termination and providing a reasonable opportunity to appeal, consistent with the requirements of proposed § 457.985.

Note that, in this final regulation, we have eliminated any specific reference to income verification systems, as income requirements are but one of a number of requirements for eligibility under a separate child health program.

Comment: One commenter expressed support for the flexibility HCFA gives States for verifying eligibility and income. Another recommended requiring that States' eligibility and income verification processes be designed to minimize barriers to and facilitate enrollment, and that the regulations explicitly provide that States may use self-declaration of income and assets. A third suggested that HCFA should include a description of the opportunity that States have to use innovative quality control projects to ensure that allowing families to self-declare income does not increase the rate of erroneous enrollment.

Response: We appreciate the support for the flexibility afforded to States and encourage States to adopt eligibility and income verification procedures that do not create barriers to enrollment. At the same time, States must have effective methods to ensure that SCHIP funds are spent on coverage for eligible children. We note that States can use their discretion in establishing reasonable verification mechanisms and have included this in the regulation text at § 457.360(b). We also encourage the creation of innovative projects to promote program integrity.

As stated in the preamble to the proposed rule, we also encourage States to develop eligibility verification systems using self-declaration or affirmation, and have decided to include this in the regulation text at § 457.360(b), to eliminate any question about the rule. States may use the existing IEVS system to verify income, as long as the information was provided voluntarily. While States may ask for voluntary disclosure of Social Security numbers, disclosure of such information cannot be made a condition of eligibility. States may use existing IEVS systems to verify income, as long as the information was provided voluntarily. We note that the integrity of a system which relies on self-declaration can be ensured through a variety of techniques. For example, a State could conduct a random post-eligibility check, requiring some applicants to provide documentation, or it could run computer matches of information provided by applicants against information available to the State through other sources.

Finally, we have deleted proposed § 457.970(a)(2) (requiring compliance with the verification and documentation requirements applicable to separate child health programs under other Federal laws and regulations) because it does not provide meaningful guidance to States on what they can and cannot do in designing their verification systems. If the system proposed violates other Federal laws or regulations, we will work with the State to bring its system into compliance.

Comment: One commenter noted his concern that the regulation authorizes States to terminate coverage of children for misconduct of a parent/caretaker and suggested that HCFA revise the definition of ''good cause'' to be more limiting. This commenter also noted his concern that the reference in proposed paragraph (d) to termination for good cause is troubling. The example of good cause as reporting false information on the application form does not seem to be good cause for a child losing benefits if the false statement does not affect the child's eligibility. The commenter stated that this kind of standard is highly subjective and susceptible to abuse given the large amount of discretion States already have in administering their plans.

Response: We agree with the commenter's concern and have deleted the good cause provisions from the regulation text accordingly. Children should not lose eligibility, as long as they meet the eligibility standards under the approved State plan and consistent with title XXI requirements. Further discussion of these issues can be found in Subpart K.

11. Review of Adverse Decisions (§ 457.365)

Finally, we proposed in the NPRM to require that States provide enrollees in separate child health programs with an opportunity to file grievances and appeals for denial, suspension, or termination of eligibility in accordance with § 457.985. In an effort to consolidate all provisions relating to review processes in new subpart K, we have removed proposed § 457.365. Comments on proposed § 457.365, are addressed in full in Subpart K—Applicant and Enrollee Protections.

D. Subpart D—Coverage and Benefits: General Provisions

1. Basis, Scope, and Applicability (§ 457.401)

As proposed, this subpart interprets and implements section 2102(a)(7) of the Act, which requires that States make assurances relating to certain types of care, including assuring quality and appropriateness of care and access to covered services; section 2103 of the Act, which outlines coverage requirements for children's health benefits; section 2109 of the Act, which describes the relation of the SCHIP program to other laws; section 2110(a), which describes child health assistance; and certain provisions of section 2110(c)(6) of the Act, which contains definitions applicable to this subpart. The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to Medicaid expansion programs even when funding is based

on the enhanced Federal medical assistance percentage. We received no comments on this section and have retained the language in this final rule.

2. Child Health Assistance and Other Definitions (§ 457.402)

Proposed § 457.402 set forth the definition of child health assistance as specified in section 2110(a) of the Act. We did not propose to include any additional services in the definition of child health assistance or attempt to further define the services set forth in the Act in order to give States flexibility to provide these services as intended under the statute. Accordingly, we proposed that the term ''child health assistance'' means payment for part or all of the cost of health benefits coverage provided to targeted low-income children through any method described in § 457.410 for any of the following services as specified in the statute:

- Inpatient hospital services.
- Outpatient hospital services.
- Physician services and surgical services.
- Clinic services (including health center services) and other ambulatory health care services.
- Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.
- Over-the-counter medications.
- Laboratory and radiological services.
- Prenatal care and prepregnancy family planning services and supplies.
- Inpatient mental health services, other than inpatient substance abuse treatment services and residential substance abuse treatment services, but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.
- Outpatient mental health services, other than outpatient substance abuse treatment services, but including services furnished in a State-operated mental hospital and including community-based services.
- Durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).
- Disposable medical supplies.
- Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)
- Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.
- Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Case management services.
- Care coordination services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.
- Hospice care.
- Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law; performed under the general supervision or at the direction of a physician; or furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.
- Premiums for private health care insurance coverage.
- Medical transportation.
- Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.
- Any other health care services or items specified by the Secretary and not excluded under this subchapter.

We proposed to define the terms ''emergency medical condition,'' ''emergency services, and ''post-stabilization services'' to give full meaning to the statutory requirement at section 2102(a)(7)(B) of the Act that States assure access to emergency services consistent with the President's directive to Federal agencies to address the Consumer Bill of Rights and Responsibilities, which includes the right to access to emergency services. We proposed to define the term ''emergency medical condition'' as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child;
- Serious impairment of bodily function; or
- Serious dysfunction of any bodily organ or part.

We proposed to define the term ''emergency services'' as covered inpatient or outpatient services that are furnished by any provider qualified to furnish emergency services without requirement for prior authorization and needed to evaluate or stabilize an emergency medical condition. Because these terms are used throughout the regulation, we have moved the definitions of ''emergency services'' and ''emergency medical condition'' to § 457.10, the overall definitions section. The comments and responses related to these definitions are addressed in § 457.10.

We proposed to define ''post-stabilization services'' to mean covered medically necessary non-emergency services furnished to an enrollee after he or she is stabilized related to the emergency medical condition.

We proposed to define ''health benefits coverage'' as an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services.

Comment: A commenter agreed that our definition of ''child health assistance'' is appropriate and considered the specific identification of advanced practice nursing services at § 457.402(a)(14) to be crucial to ensuring that children in fact receive the care to which they are entitled by statute.

Response: We appreciate the commenter's support for our definition. The proposed regulation set forth the definition of child health assistance as specified in section 2110(a) of the Act. The provision of advanced practice nursing services is specifically identified in that section as a coverable service.

Comment: One commenter questioned why well-baby care, well-child care and immunizations are not explicitly included in the list of definitions. These benefits are the cornerstone of pediatric care and the commenter indicated that it is important that they are explicitly included wherever appropriate.

Response: Section 2102(a)(7) of the Act provides the authority for requiring that well-baby and well-child care and immunizations be included under every State plan. Well-baby and well-child care and immunizations were not specified in the statutory definition of ''child health assistance'' at section 2110 of the Act, although they clearly fall within this definition of ''child health assistance.'' Additionally, well-baby and well-child care are not separate categories of services, but can include services that are in any or all of the separately defined categories of services. However, because these terms are used throughout the regulation we have included them in the definitions at § 457.10. These services are also discussed at §§ 457.410 and 457.520.

Comment: One commenter was concerned about the definition of post-stabilization services and the language in the preamble stating that HCFA would expect States and their contractors to treat post-stabilization services in the same manner as required for the Medicare and Medicaid programs, while recognizing that not all such services would be necessarily covered by the State for purposes of SCHIP.

While the commenter did not object to permitting States to apply to separate child health programs an interpretation of post-stabilization services that is the same as that under Medicaid and Medicare, they believed that HCFA should give States flexibility to treat the coverage of post-stabilization services differently depending upon the structure of the State program. A State that designs its separate child health program to mirror its Medicaid program would want to retain the same interpretation for both programs. However, a State that models its program after commercial coverage would want to adopt an interpretation that is applicable to commercial coverage that is offered by MCEs. Such flexibility would be particularly important if the State decides to provide coverage to SCHIP eligibles by purchasing coverage from employer group health plans to cover children. In those cases, the emergency services requirement should parallel those applicable to the employer's group health insurance coverage. The commenter recommended that the proposed regulation be revised to reflect this needed flexibility.

To the extent that States adopt or HCFA requires use of the interpretation of the post-stabilization services requirements applicable under the Medicaid and Medicare programs, the commenter reiterated its comments on the Medicaid managed care notice of proposed rulemaking and the interim final Medicare+Choice regulation. The issue of concern to this commenter was whether the requirement that Managed Care Entities (MCEs) respond to requests for approval of post-stabilization services within one hour is reasonable.

The commenter expressed considerable concern about requirements for post-stabilization care for MCEs, particularly the requirement that MCEs respond to requests for approval of post-stabilization care within one hour. The commenter suggested conditions to moderate the effect of this requirement.

Response: We agree with the commenter that States should have the flexibility to treat coverage of post-stabilization services differently depending on the health benefits coverage elected by the State. The preamble to the proposed rule may have been misleading by appearing to require the provision of post-stabilization services under a separate child health program, therefore, we have removed the references to post-stabilization services, covered or otherwise, from the final rule. We hope that this will minimize confusion.

Comment: Several commenters on proposed § 457.995 had other concerns regarding the provision of post-stabilization services for individuals in managed care. These commenters expressed concern that managed care organizations should be allowed to control their own networks. A payment network needs the flexibility to require a patient to be transferred to an appropriate facility within its network after the emergency has been stabilized. According to these commenters, this regulation takes the control of non-emergency services away from the network and gives it to a non-network provider and could defeat the concept of managed care. The commenters believed that when emergency care is provided outside of the MCE network, it is usual and customary for the patient to be transferred to an appropriate facility within their MCE network for required post-stabilization services.

Response: Proposed § 457.995(d), the provision in the overview of beneficiary rights referencing post-stabilization services, has been removed from the regulations text along with the rest of § 457.995 for the sake of clarity and consistency.

Comment: One commenter noted that the preamble to the proposed rule indicates that HCFA considered defining transportation to include coverage for transportation to more than primary and preventive health care as stated in the law. However, the commenter noted that HCFA decided to leave the option of establishing the definition to the States. The commenter regarded transportation as including urgent and emergent care and that transfer/transport to a hospital or health facility for urgent and emergent care should be included in a child's health benefit package.

Response: Under the list of services in section 2110(a) of the Act and § 457.402 of this final regulation, transportation is mentioned in two different items: (26) medical transportation and (27) enabling services (such as transportation, * * *). While coverage for transportation services is not required, almost every State already provides coverage for emergency transportation under its State plan. Therefore, we do not see lack of coverage of this service as a problem and will not further define transportation services.

Comment: We received several comments on proposed § 457.402(a)(26), redesignated as paragraph (27), which provides for enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals. One commenter indicated that States should be required to fund community health centers to provide outreach activities and enabling services such as translation and transportation (rather than, or in addition to, outreach costs that are reimbursed under administrative accounts).

Several other commenters indicated that the phrase ''outreach services * * * only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals'' is ambiguous and requested clarification. They noted that this phrase could be read to permit a State to pay primary health providers such as health centers to conduct outreach activities to find eligible children as part of their overall child health assistance services (rather than, or in addition to, outreach costs that are reimbursed under administrative accounts). The commenter noted that this is important because the SCHIP statute caps States' overall administrative costs and thus has been viewed as providing insufficient funds to support the types of outreach efforts that experts say are necessary to find eligible children. To the extent that the phrase ''outreach * * * to eligible low-income individuals'' is interpreted as the identification of eligible children, then this represents an important option

for States and health centers. States could build outreach funds into their payments to SCHIP primary care providers, along with funding for other forms of enabling services, such as translation and transportation costs.

In the context of payment to primary health care providers, one commenter also indicated that States could build funds for outreach and enabling services into their payments to SCHIP primary care providers. The commenter indicated that community clinics and health centers in its State are encountering difficulties and confusion when being audited for purposes of receiving cost-based reimbursement from the State.

Response: In developing their State plans, States determine their own providers. We cannot require that community health centers be funded to provide outreach and enabling activities. The language of proposed § 457.402(a)(26) was taken directly from the language at section 2110(a)(27) of the Act. Enabling services, including outreach to assist children's access to primary and preventive care, are one of the types of services States may choose to provide as part of the ''child health assistance'' that meets the requirements of section 2103 of the Act. We note that under the terms of section 2110(a) and 2110(a)(27), these services must be delivered to ''targeted low-income children'' who are ''eligible'' for ''child health assistance'' under the State plan. Therefore, when enabling services are provided as part of the health benefits coverage for children who are found eligible and enrolled, these services would not be subject to the 10 percent cap on administrative expenditures under 2105(c) of the Act. However, outreach initiatives to potentially eligible children are subject to the 10 percent cap in accordance with section 2105(a)(2)(C) of the Act. We do not understand the commenter's specific concerns regarding difficulties in receiving cost-based reimbursement in the State's community clinics and health centers so we are unable to respond to this comment. (We note that, in this final rule, we have listed physician services and surgical services (proposed § 457.402(a)(3)) separately as paragraphs (3) and (4), respectively. As a result, the services listed at paragraphs (a)(4) through (a)(27) have been redesignated as paragraphs (5) through (28). Enabling services are now listed at paragraph (27).)

Comment: One commenter noted its belief that the preamble should encourage States, in selecting among benefits to cover, to consider the needs of different age groups, their varying health status and patterns of morbidity and mortality, the impact of developmental states on their needs and their patterns of utilization. They observe, for example, that coverage of over-the-counter medications may be of particular benefit to adolescents. Also, eating disorders are more common among adolescents than younger children, and family planning services should include a choice among all contraceptive methods and options.

Response: We concur with the commenter and encourage States to consider the populations they are serving and the needs of different age groups when designing their benefit package States need only cover medically necessary and appropriate services, but the statute at section 2102(a)(7) and the regulations at § 457.495, specifically require States to specify the methods they will use to assure appropriate care.

Comment: Two commenters noted that the language on services in the proposed rule was set out identically to the language in the statute. The commenters were concerned that the definition of both inpatient and outpatient mental health services excludes substance abuse treatment services, which are listed separately in the statute and the regulation. One commenter was concerned that this separation means only that payment may be made for these services, not that payment shall be made for these services and believes that States should be encouraged to consider their inclusion for comprehensive treatment for adolescents with co-occurring mental and substance abuse disorders.

Similarly, another commenter is concerned that the separation of outpatient substance abuse treatment services may allow the provision of outpatient mental health services but not the provision of outpatient substance abuse services, but would include services furnished in a State-operated mental hospital and community-based services. The commenters indicated that substance abuse impacts a significant number of children in their States and rather than removing this important benefit, they recommended that the regulations need to encourage and even highlight the importance of offering this benefit.

The commenter noted that while the listings for mental health inpatient and outpatient services in the regulations specifically exclude substance abuse services, these services are listed separately from inpatient and outpatient mental health services. The commenter called attention to this because of the high incidence of co-occurring disorders among adolescents with presenting symptoms of one or the other. Even though these services lack the 75 percent actuarial measure required when mental health services (and/or prescription drugs, vision and hearing services) are included, States should consider their inclusion for comprehensive treatment of adolescents with co-occurring mental and substance abuse disorders.

Response: We appreciate the commenter's view about the importance of respite care services. As we have indicated previously, the proposed rule at § 457.402 mirrors the language of section 2110(a). Therefore, inpatient mental health services and inpatient substance abuse treatment services, as well as outpatient mental health services, and outpatient substance abuse treatment services are listed separately in the regulation as they were in the statute. States choose to cover services from the list of services under the definition of ''child health assistance'' when they select a health benefits coverage option under § 457.410. The statute supports mandating that only three types of services, well-baby and well-child services, immunizations, and emergency services, be included in all SCHIP plans regardless of the type of health benefits coverage chosen. HCFA encourages States to provide inpatient and outpatient substance abuse services. A State may choose to provide inpatient mental health and substance abuse services; however the statute provides flexibility for the States in determining the scope of covered benefits.

We do, however, call the commenter's attention to the requirement in § 457.120 of the regulations for ongoing public input in the development and implementation of SCHIP plans. Comments and concerns about benefits and coverage should be directed to and taken under consideration by the State SCHIP agency. We encourage States to consider the populations they are serving and the needs of different age groups when designing their benefit packages.

Comment: One commenter particularly noted the inclusion in § 457.402 of ''respite care services and training for family members,'' which are especially relevant to families with children with severe and persistent mental illness or brain disorders. The commenter stated that it would appreciate attention being called to these services' eligibility for coverage and relevance in plans that offer supplemental mental health services, in addition to other services, ''*i.e.,* respite care, advanced practice nurse services,

and pediatric nurse services * * * in a home, school or other setting.''

Response: As we have indicated previously, States that implement separate child health programs are given broad flexibility to design their benefit packages. We encourage commenters to work with their States to assure that valuable health care services are made available to children to the extent possible in each State.

Comment: One commenter recommended § 457.402 be deleted because the statute provides States with flexibility in the design of the SCHIP benefit package and this section implies that coverage for certain services should be available under SCHIP when it is not required by statute and may not be included in the state-designed benefit package.

Response: Section 2110 of the Act allows for payment for part or all of the cost of health benefits coverage (as defined at § 457.10) for any services listed in section 2110(a) of the Act as implemented in § 457.402. These provisions do not indicate that States must provide all of these services; rather, they list the array of services for which payment may be made. We disagree with the commenter and have not deleted this section from the proposed rule.

3. Health Benefits Coverage Options (§ 457.410)

Under the authority of section 2103 of the Act, at proposed § 457.410, we listed the four options a State has for obtaining health benefits coverage for eligible children. Specifically, we proposed that States may choose to provide benchmark coverage, benchmark-equivalent coverage, existing comprehensive State-based coverage, or Secretary-approved coverage. These four options are described at §§ 457.420 through 457.450.

Based on the authority of section 2102(a)(7) of the Act, we also proposed at § 457.410(b) to require that a State must obtain coverage for well-baby and well-child care, immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP), and emergency services. We noted that the State must cover these services even if coverage for these services is not generally included in the health benefits coverage option selected by the State.

We proposed to define well-baby and well-child care for purposes of cost sharing at proposed § 457.520(b), but we proposed to allow States to define well-baby and well-child care for coverage purposes. We encouraged States, however, to adopt the benefits and periodicity schedules recommended by a medical or professional organization involved in child health care when defining well-baby and well-child care coverage.

Comment: Two commenters supported the requirement that States use the ACIP schedule for immunizations under their separate child health programs. However, many commenters disagreed with the proposal that States be required to follow the immunization schedule of the ACIP, particularly because they are not allowed to participate in the VFC program. It was suggested that States should be able to adopt their own immunization periodicity schedules. One commenter suggested that we rewrite this section to require ''immunizations as medically necessary'' rather than require that immunizations be provided according to the ACIP schedule. Several commenters suggested that a State that utilizes existing commercial health plans may not use any particular standard immunization schedule or may follow other professional standards. One commenter mentioned that its State uses another standard, the recommended childhood immunization schedule jointly adopted by the American Academy of Pediatrics (AAP), the ACIP, and the American Academy of Family Physicians (AAFP).

Response: Section 2102(a)(7)(A) requires that a State child health plan include a description of a State's methods to assure the quality and appropriateness of care, ''particularly with respect to * * * immunizations provided under the plan.'' In order to ensure that all SCHIP children are appropriately immunized, States should use a uniform, nationally recognized schedule of immunizations. The ACIP schedule referred to in the proposed rule is a harmonized schedule approved by the ACIP, the AAP, and the AAFP. It is referred to as the ''Childhood Immunization Schedule of the United States.'' The AAP and AAFP no longer develop and maintain separate immunization schedules but rather use the harmonized ACIP schedule. This ACIP schedule is the same as the standard referenced by one of the commenters as the schedule relied on by its State. States should use the ACIP schedule because it reflects the current standards of these pediatric speciality providers who are the recognized authorities in childhood immunizations.

Comment: Several commenters expressed their belief that requiring SCHIP programs to use the ACIP immunization schedule is overly prescriptive and has no basis in the statute. According to one commenter, the only statutory limit on States' discretion is found in section 2102(a)(7)(A), which indicates that the State plan must include a description of the methods used to assure the quality and appropriateness of care, particularly with respect to immunizations. The commenter cited Executive Order 13132 on federalism, and asserted that, consistent with that authority, States should be permitted to select their own immunization standards unless HCFA can demonstrate both a need for a federal standard and that it has considered alternatives that would preserve the States' prerogatives.

Response: As described in the response to the previous comment, section 2102(a)(7)(A) of the Act provided authority to require immunizations in accordance with the recommendations of ACIP. Therefore, the requirement to use the ACIP schedule is not a violation of E.O. 13132. The ACIP schedule is a national standard developed and approved by three national medical organizations involved in child health care services, the ACIP, the AAP and the AAFP. These organizations use the harmonized ACIP immunization schedule and no longer use separate immunization schedules. Requiring coverage for appropriate immunizations at appropriate times, as the ACIP schedule recommends, does not place undue burden on States given the importance of childhood immunizations. In fact, it releases States from the burden of having to develop or choose their own individual schedules and establish the adequacy of those schedules with respect to title XXI statutory requirements. Given the unique nature of infectious diseases, and the mobility of the population across State lines, it is necessary to require a uniform approach to immunizing children across all States.

Comment: One commenter believed the 90-day requirement explained in the preamble to the proposed rule for States to adhere to any changes in the ACIP recommendations is inappropriate. The current policy is that States have 90 days from the publication of the revised ACIP schedule in the Morbidity and Mortality Weekly Report to implement those changes in their programs. The commenter believed that this requirement fails to recognize the realities of effectuating such a change in benefits. States should have until the end of the current contract period but in no case longer than one year to comply with any ACIP changes.

Response: It is essential for children to receive vaccines according to the most current ACIP recommendations in

order to maximize children's health, minimize morbidity and mortality, and reduce costs of treating preventable disease. In addition, good public health policy argues for consistent adoption of vaccine recommendations across all States in order to minimize the potential for transmission of communicable disease.

Comment: One commenter expressed its opinion on the importance of children in separate child health programs receiving all necessary immunizations and of vaccines being incorporated in all benefit packages. The commenter also suggested two ways that States may provide immunizations through their SCHIP programs without opening up the VFC program: (1) a State may add on payments for the provision of immunizations through participating MCEs; or (2) the State may declare that children enrolled under a separate child health program are State vaccine eligible. The State may then purchase the vaccines at the Federal contract price and distribute them to SCHIP providers as it currently does for Medicaid providers. The commenter stated that expenditures under either of these options would be matched by the Federal government at the SCHIP enhanced matching rate and would not count as administrative expenditures under the 10 percent cap. Additionally, the commenter believed that the State should require that plan contracts include provisions that require plans to provide and cover additional expenses for vaccines that are approved and recommended for all children during the life of the contract.

Response: We agree with the commenter that children in separate child health programs should receive all recommended immunizations, as should children in Medicaid expansion and combination programs. Also, regardless of the type of child health insurance program the State chooses, we agree with the suggestion that MCE contracts should provide that the MCEs furnish all vaccines, including new vaccines, recommended during the term of the contract.

However, regardless of whether the State chooses to include such a contract provision, States must furnish vaccines in accordance with the recommendations of the ACIP. States should furnish newly recommended vaccines to all eligible children within 90 days after the recommendation is published in Morbidity and Mortality Weekly Report. This report is available over the Internet at *www.cdc.gov/mmwr.*

We outlined ways that States could take advantage of the Federal discount contract price for vaccines in a letter dated June 25, 1999 to all State Health Officials. As stated in that letter, expenditures for vaccines will be matched by the Federal government at the enhanced SCHIP matching rate and will not count as expenditures subject to the 10 percent cap on administrative expenditures under section 2105(c)(2) of the Act, regardless of whether the State takes advantage of the Federal discount contracts.

Comment: Many commenters recommended that HCFA reconsider its position on the Vaccines For Children (VFC) program for various reasons. One commenter indicated that in light of national immunization goals not yet having been achieved, HCFA should not consider SCHIP enrolled children to be insured and therefore ineligible for free VFC vaccines. Several commenters expressed that States that have elected to implement separate child health programs are being unfairly penalized for not choosing to expand their Medicaid programs.

One commenter indicated that because the SCHIP statute states absolutely that the legislation creates no entitlement, and because the VFC program defines insurance as benefits to which an individual is entitled, it would appear to be clear that, despite their eligibility for SCHIP, children in separate child health programs are not entitled to insurance and thus should be considered VFC-eligible. One commenter also stated that having seen polio epidemics and iron lung machines, HCFA should be working to reduce barriers that prevent many children from getting vaccinated so that epidemic childhood diseases do not become more prevalent in the United States as they are in other countries. One commenter believed that the interpretation of section 316 of the Public Health Service Act, which is used to support the policy that separate child health programs are not eligible to participate in VFC, is overly strict and does not align with the intent of the Act to insure that children receive necessary immunizations.

Response: We agree with the commenter that the intent of the statute is that all children should receive necessary immunizations, and therefore require at § 457.410(b)(2) that all States with separate child health programs provide coverage for immunizations in accordance with the recommendations of the ACIP. We disagree with the commenters only as to whether the VFC program or SCHIP funds cover the cost of required immunizations. We disagree that the VFC program allows payment for immunizations provided to a child enrolled in a separate child health plan. As explained in a letter to State Health Officials of May 11, 1998, section 1928(b)(2) of the Act defines a ''Federally vaccine-eligible child'' or a child who is entitled to free Federal vaccines under the VFC program, as ''a Medicaid-eligible child, * * * a child who is not insured, * * * a child who is (1)administered a qualified pediatric vaccine by a Federally-qualified health center * * * or a rural health clinic * * * and (2) is not insured with respect to the vaccine, [or] a child who is an Indian * * * '' The law further defines the term ''insured'' as a child '' * * * enrolled under, and entitled to benefits under, a health insurance policy or plan, including a group health plan, a prepaid health plan, or an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 * * * '' The distinction between Medicaid coverage and other coverage is created by the VFC statute. Under the SCHIP statute, it is clear that children who are enrolled in a separate child health program must not be Medicaid-eligible, as explained in § 457.310(b)(2) of these regulations. They are enrolled under, and entitled to benefits under, a health insurance policy or plan within the definition in section 1928 (b)(2)(B)(ii), as explained above, and their insurance covers the cost of vaccines. Although there is no Federal entitlement to SCHIP coverage, a child who is enrolled in a SCHIP-funded plan is ''entitled'' to coverage under that plan just as a child enrolled under a group health plan is ''entitled'' to coverage under the group health plan. Unless they are Indians, children enrolled in SCHIP are not Federally vaccine-eligible under current law. Therefore, the Secretary cannot reconsider her decision on this matter without a change in the law that would define a child enrolled in a separate child health program as a Federally vaccine-eligible child.

Comment: One commenter indicated that it appears that the exclusion of SCHIP children from the VFC program would cause the SCHIP program to be less cost effective than the Medicaid program. The commenter asked if this policy means that States may use this provision as a cost offset in discussions of the revenue neutrality of the SCHIP program design. The Federal government, by design, assures that the SCHIP program will be more expensive in that it must pay for a service that is free under Medicaid.

Response: We do not understand the intent of this comment, as the concept of budget neutrality does not apply to the SCHIP program design. While immunizations are required to be

covered under a separate child health plan, States have discretion to determine what other services will be provided under their State plans, and the amount, scope, and duration of those services.

Comment: One commenter noted that it is crucial that any expansion of health care services in State plans include coverage for essential oral health care benefits. Historically, the number of dentists participating in State Medicaid programs is low. This low participation has prevented most poor children from developing good oral hygiene habits. SCHIP allows States to include oral health care services in their State plans and the commenter urged HCFA to consider this as an important component of increasing the overall health of America's rural children as the agency reviews State plans.

Response: We agree with the commenter that oral health is an integral part of the overall health of children and have engaged in a serious effort to promote oral health, as described earlier in a response to comments on this subpart. However, we do not have the statutory authority to require that States provide any specific services under their SCHIP plans other than those required under sections 2102(a)(7)(A) and 2103(c) of the Act. Although we do not have the authority to require the inclusion of these services, because of the importance of oral health services for children, we have included in the definition of well-baby and well-child care, for purposes of cost-sharing restrictions at § 457.520(b)(5), routine and preventive and diagnostic dental services. Accordingly, a separate child health plan may not impose copayments, deductibles, coinsurance or other cost-sharing for these services. Nonetheless, all but two States with separate child health programs have opted to provide coverage for some type of oral health services.

Comment: One commenter recommended that the regulation clarify that children enrolled under a Medicaid expansion program are entitled to all medically necessary services to the same extent as under the Medicaid EPSDT service and that the services for these children would not be considered a State option.

Response: The regulation indicates in § 457.401(c) that the information in this subpart does not apply to Medicaid expansion programs. Therefore, because this subpart addresses only provisions regarding separate children's health insurance programs, we have not added additional language to the regulation text to indicate that children enrolled under Medicaid expansion programs are eligible for Medicaid's EPSDT services. However, as we have made clear in the preamble to the proposed regulation and in other guidance, all Medicaid benefit rules, including rules requiring EPSDT services, apply fully to children enrolled in Medicaid expansion programs.

Comment: One commenter noted that the Medicaid program includes coverage for children with serious and severe mental illnesses. The commenter urged HCFA to collaborate with those States opting to develop separate child health programs to provide health coverage for the same level of treatment and service currently provided by Medicaid. Another commenter noted the importance of behavioral health as an integral part of a child's overall well being. According to this commenter, while rural families and children suffer mental disorders similar to those suffered by their urban counterparts, rural residents are less likely to receive treatment in part because of the extreme lack of behavioral health professionals in rural communities. The commenter strongly supported inclusion of coverage for mental health services in the State plans for the SCHIP program.

Response: We agree that mental health is an integral part of the overall health of a child and we urge States to consider providing these services. However, a requirement that States include any specific services in their State plans other than those required under 2102(a)(7)(A) and 2103(c) of the Act and specified under § 457.410(b) would be inconsistent with title XXI.

Comment: One commenter asked why the discussion of § 457.410(b) in the preamble to the proposed regulation about offering different health benefits coverage for children with special needs refers only to children with physical disabilities, and not mental disabilities. Such children may be encompassed within the category of special needs, but the additional listing only of physical disabilities gives the false impression that disability cannot be mental as well.

Response: We did not intend to exclude any type of illness, physical or mental, by using the example of children with physical disabilities in discussing the States' option to offer different health benefits coverage. The preamble noted that States can have more than one benefit package that meets the requirements of the subpart, including one designed for children with special needs or physical disabilities. We were simply giving one example of a population to which States may want to consider offering additional services or a special package of services and did not mean to offer the example as the only option. States should consider the needs of children with mental disabilities as they consider whether to adopt benefit packages designed specifically for children with special needs.

Comment: One commenter supported the preamble language to proposed § 457.410, which indicates that States can include in their comprehensive health benefits package ''supplemental services for children with special needs or physical disabilities'' and alternatively may offer multiple benefit packages. Such an approach permits States to expand services to children with special health care needs without regard to the 10 percent cap on Federally-matchable expenditures ''for other than the comprehensive services packages.'' The commenter supported this approach to increasing States' ability to help such children.

However, numerous commenters were concerned with this language in the preamble to proposed § 457.410. Several commenters expressed concern about the language in the proposed rule stating that if a State offers a supplemental package of limited services for children with special health care needs that is not part of the comprehensive coverage required by the regulation, then expenditures for those extra services would be counted against the 10 percent cap on administrative expenses under section 2105(c)(2) of the Act. They noted that a number of States have implemented SCHIP with supplemental benefits packages, or ''wrap-around packages'', for coverage of services for eligible children with special health care needs and that this is an important, appropriate and beneficial strategy for the provision of needed health care services for children. They indicated that requiring that expenditures for services for children with special health care needs count against the 10 percent cap would encourage States to limit the services that are offered to these children, which could affect their overall health and well being. The commenters argued very strongly that services for children with special health care needs that are provided through an additional limited benefits package should not be counted against the 10 percent cap, and that making them subject to the cap has the potential to discourage the development of creative benefit packages for children with special needs.

Two commenters questioned whether the Department intended to indicate that such initiatives are subject to the 10 percent administrative cap as section 2105(a)(2) makes no mention of special needs. The commenters recommended

that the preamble be modified by dropping the reference to special needs since this reference may be misconstrued when States are designing and implementing certain benefit packages for special needs children. The commenters indicated that the statute contemplates that there are permissible health initiatives which would be subject to the 10 percent cap and suggested that this section of the preamble be written to identify the types of initiatives subject to the limitation without calling into question those benefits packages for children not subject to the 10 percent cap.

One commenter cautioned States about the manner in which they define children with special health care needs. The commenter provided suggested language that States should be encouraged to use to define children with special health care needs.

One commenter believed that the explanation of required coverage in the preamble to the proposed rule forces States either to provide a comprehensive benefit package that is above and beyond the needs of the ''average'' child in order to ensure that the needs of special needs children are met, or to put administrative dollars at risk. By providing such a comprehensive benefit package, the capitated rate paid to health plans to pay for such services will significantly increase.

One commenter also noted that while the rules permit separate packages of services consistent with the ADA, the 10 percent cap is troubling and it is unclear what the potential impact will be or if this could penalize children and their families in unexpected ways.

Response: Unfortunately, the language in the preamble to the proposed rule about the application of the 10 percent administrative cap in connection with supplemental services for children with special needs caused much confusion to commenters. We will attempt to clarify below.

Under section 2105(a)(1), States may receive enhanced FMAP for expenditures for child health assistance for targeted low-income children provided in the form of health benefits coverage that meets the requirements of section 2103 of the Act. Under section 2105(a)(2) States may receive payment of a federal share of State expenditures for other items but expenditures for these other items are subject to the 10 percent administrative cap under section 2105(c)(2). A State has two options for providing more health benefits coverage to special needs children under which the expenditures for the coverage are not subject to the 10 percent cap on administrative expenditures. The first option would be for the State to have a separate eligibility group for the identified special needs children with a larger health benefits package than for other eligibility groups. The State would have to design the eligibility group without violating the statutory requirement under section 2102(b)(1)(a) of the Act that the eligibility standards ''not discriminate on the basis of diagnosis.'' The second option would be for the State to retain the general eligibility group that includes all children and include in the health benefits coverage package coverage for services needed by special needs children. The package could include limitations for coverage on these services (consistent with other benefits requirements) to ensure that they would be available primarily to special needs children. Under either option, the special needs coverage is part of an overall health benefits coverage package that is consistent with section 2103 of the Act and § 457.410 of the final regulation.

One key aspect of section 2105(a)(2) is that SCHIP funds can be used for health services initiatives for targeted low-income children as well as other low-income children. With respect to the suggestion that we include some examples of public health initiatives that would be subject to the 10 percent cap, we are including the following examples, some of which were proposed by one State: (1) access to mental health services for low-income children in the Juvenile Court System; (2) health care outreach and services for homeless children and adolescents; (3) mental health services for low-income children with special needs; (4) dental care for low-income children and their families; (5) health care services for migrant children; and (6) an immunization project for low-income children who are not enrolled in Medicaid or SCHIP. As we indicated, these are just a few examples for use of title XXI funds for public health initiatives as authorized by section 2105(a)(2) of the Act. States are free to develop and propose initiatives which are specific to the needs of their population.

Comment: One commenter noted that it was pleased that we have included a reference to Bright Futures in the proposed rule but encouraged that we use the term ''well-adolescent'' whenever we refer to ''well-child'' and the term ''age'' when offering examples of diverse populations.

Response: Under the definition of ''child'' set forth in section 2110(c)(1) of the Act, and implemented in § 457.10 of this final regulation, ''child'' is an ''individual under the age of 19.'' An adolescent clearly fits within this definition of child, and therefore we have not accepted the commenter's suggestion to use the term ''well-adolescent'' whenever we refer to well-child care. In addition, as we explained above, we did not intend to exclude any particular group or condition in describing a special population that States may want to consider offering additional services or a special package of services. Therefore, we have not added ''age'' to the example we used in the preamble.

Comment: One commenter indicated that there are various ways for separate child health programs to make health benefits coverage available to enrolled children. States may use direct, fee-for-service coverage or can operate as primary care case managers. Separate child health programs can also buy benchmark or benchmark-equivalent coverage provided through an MCE. The commenter went on to say that what is listed as a class of covered benefits in the State plan may not be precisely what is covered if the State chooses to offer coverage solely through a benchmark or benchmark-equivalent package that is purchased from a participating insurer or MCE. Furthermore, the insurer or MCE may apply limits to coverage that would not apply if the coverage were obtained directly through the State-based plan. Finally, the proposed rules on coverage do not require any particular standard for the measurement of medical necessity for children, either by the State or by benchmark insurers.

According to the commenter, because the benchmark plans may differ from the State comprehensive package and no specific medical necessity standard is required for separate child health programs, the issue of disclosure of coverage and coverage limitations becomes important. Both providers and families will need to have clear, understandable materials and information regarding what is and is not covered, as well as the limitations that apply to covered benefits. The commenter cautioned that benchmark plans may not be appropriately designed for children; for example, the plan may provide coverage for speech therapy after a stroke but no coverage for speech therapy to address developmental delays. There is nothing in the proposed rule that requires benchmark plans to be designed to meet the specific health needs of children.

Response: In order for a State plan to be approved, the State must indicate what type of health benefits coverage it is electing to provide. The State must make available to enrollees the full

coverage package defined in its State plan, and may not permit contractors to restrict that coverage. While neither the State nor a contractor is required to furnish medically unnecessary services, they cannot alter the basic coverage package from that specified in the State plan.

Because SCHIP is targeted for children under the age of 19, States must ensure that the health benefits coverage it elects to provide is appropriate for the population being served. The statute addresses the issue of appropriateness of coverage through the coverage requirements at section 2103 of the Act, which sets forth the required scope of health insurance coverage under a separate child health program. In addition, based on the authority of section 2102(a)(7) of the Act, we have required coverage for well-baby and well-child care, immunizations and emergency services. Finally, if a State elects to use benchmark-equivalent coverage, it must cover specific services listed at section 2103(c)(1) of the Act and be actuarially equivalent for additional services covered under one of the benchmark benefit packages. While we have not defined medical necessity for purposes of separate child health programs, we believe that the requirements of the statute and final regulations ensure the appropriateness of coverage for children in separate child health programs.

With respect to the commenter's concerns regarding the availability of understandable materials, we refer the commenter to the requirements at § 457.110(b) and § 457.525 which discuss the requirements for making certain information available and for information on the public schedule for cost sharing.

Comment: Several commenters agreed with HCFA's suggestion in the preamble to proposed § 457.410 that SCHIP programs use the AAP guidelines and/or Bright Futures periodicity schedules. However, they did not agree with HCFA's reasoning for not requiring States to adopt this definition of well-baby and well-child for benefit coverage. One commenter indicated that Medicaid guarantees children coverage of medically necessary services through EPSDT, while separate child health programs do not provide the same guarantee. It is therefore more critical and appropriate for HCFA to place specific requirements on the provision of services because there is no underlying entitlement, and HCFA should establish an appropriate floor. Another commenter indicated that because Medicaid uses the EPSDT standard for its schedule of periodicity, the schedule should be included for SCHIP coverage to be consistent and allow parity. Rather than merely recommending periodicity schedules, HCFA should require that an endorsed professional standard be adopted by SCHIP programs. Allowing States to devise their own schedules could leave children in different States with widely different coverage under SCHIP.

Response: For a number of reasons, we are not requiring States to use for coverage and other purposes the definition of well-baby and well-child care that is required for purposes of cost sharing. Specifically, HCFA wanted to assure States the flexibility accorded them under the statute in developing their SCHIP benefit packages, including their well-baby and well-child care packages. In addition, there are several expert groups that have developed professional standards for the delivery of well-baby and well-child care. These standards include those developed by the AAP, AAPD and the Bright Futures standards. HCFA has not endorsed any particular professional standard for well-baby and well-child care for Medicaid and we did not feel we should impose a more stringent standard on SCHIP plans. We have included a definition of well-baby and well-child care for purposes of cost sharing because Congress established basic rules for cost sharing that must be applied on a consistent basis across States.

The commenter is correct that under the Medicaid program, EPSDT services are mandatory for most Medicaid eligible children under the age of 21. However, the SCHIP statute did not require this comprehensive service package for children in separate child health programs but rather gave States the flexibility to design their own benefit packages within certain parameters.

With respect to the use of a specific periodicity schedule, the commenter is incorrect that EPSDT services require any specific periodicity schedule. HCFA cannot, by law, require States to use any particular periodicity schedule for the delivery of EPSDT services under Medicaid. The EPSDT statute at section 1905(r) specifies that each State must develop its own periodicity schedule for screening, vision, hearing and dental services after appropriate consultations with medical and dental organizations involved in child health care. In the proposed rule, we suggested that States use one of the professional standards already developed in determining their well-baby and well-child care benefit packages; however, we have declined to require the use of a specific schedule. There are several professional standards that are acceptable for States to adopt. In fact, many States have adopted one of those standards for use in their EPSDT programs also. This policy does present the possibility, as the commenter suggests, that children may be treated differently in different States. However, this is allowable under title XXI.

Comment: One commenter believed that States should be able to retain discretion to define well-baby and well-child care more broadly than § 457.520 and that HCFA should require States to follow the AAP and Bright Futures periodicity schedules in both Medicaid and SCHIP programs. In particular, many States have not yet adopted a periodicity schedule providing for annual health assessments for adolescents, even though there is consensus among the professional community that adolescents should receive annual assessments.

Response: If a State chooses to define well-baby and well-child care more broadly than defined in § 457.520 for cost sharing purposes in order to limit cost sharing for a broader range of services, the State is free to do so. It is true that some States have not adopted periodicity schedules to allow for annual assessment of adolescents under their Medicaid program. While both programs allow for that flexibility in adopting periodicity schedules, HCFA encourages States to ensure that their periodicity schedules reflect current professional standards.

Comment: One commenter recommended that the AMA's Guidelines for Adolescent Preventive Services (GAPS) be added to the list of appropriate standards for States to consider.

Response: We agree that GAPS is an appropriate standard for States to use in defining well-child care periodicity schedules for adolescents and recommend that States consider this standard as well.

Comment: One commenter reiterated that the preamble language indicates that well-baby and well-child care includes health care for adolescents and is subject to the cost-sharing prohibitions, but is ambiguous as to whether a State has to provide coverage for these services or merely apply the cost-sharing prohibitions to those services that they cover. The commenter believed that States should be required to provide such coverage. The commenter also urged HCFA to add language to the preamble encouraging States to consider the special problems that affect adolescents (for example, eating disorders) when defining special needs.

Response: We appreciate the commenter's concern about adolescents. States are required to provide coverage for well-baby and well-child care services under any separate child health plan but may specifically define those services as they choose. We note that we have revised § 457.410(b)(1) to provide that the State must obtain well-baby and well-child care services as defined by the coverage for the State. Cost sharing is not allowed for any services covered under a separate child health program that are included in the definition of well-baby and well-child care at § 457.520. We have not included language encouraging States to consider special problems that affect adolescents when defining special needs. However, we urge States to consider the special needs of the population being served by the separate child health plan.

Comment: One commenter recommended § 475.410(b) be deleted because the statute provides States with the flexibility to adopt a benchmark plan or to develop an actuarially equivalent benefit package.

Response: We have not adopted this suggestion. The commenter correctly notes that the SCHIP statute provides States with flexibility to adopt benchmark health benefits coverage or actuarially equivalent benefit-equivalent health benefits coverage when designing their programs. However, in accordance with section 2102(a)(7), § 457.410(b) ensures that enrollees in separate child health programs receive coverage for certain basic services.

4. Benchmark Health Benefits Coverage (§ 457.420)

Section 2103(b) of the Act sets forth the benchmark health benefits coverage from which a State may choose in accordance with section 2103(a)(1) of the Act. We proposed to implement these statutory provisions at § 457.420. We proposed to define benchmark health benefits coverage as health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit packages:

- The Federal Employee Health Benefits Program (FEHBP) Blue Cross/Blue Shield Standard Option Service Benefit Plan with Preferred Provider arrangements;
- A health benefits plan that the State offers and makes generally available to its own employees; or
- A plan offered by a Health Maintenance Organization (HMO) that has the largest insured commercial, non-Medicaid enrollment of any such plan in the State.

We discussed each option for benchmark health benefits coverage in detail in the preamble of the proposed rule. We noted that when a State chooses to increase, decrease, or substitute coverage available under its approved State plan, a State must submit a State plan amendment for approval if the change in benefits is intended to conform the separate State benefit package to the benchmark coverage. But if the change in benefits causes the State offered benefits to differ from the benchmark coverage, then the benefits must be reclassified as benchmark equivalent or one of the other benefit package options.

We also noted that section 2103(a)(1) of the Act provides that benchmark coverage must be ''equivalent'' to the benefits coverage in a reference benchmark benefit package. We stated that we would interpret this language to mean that coverage must be ''substantially equal'' to benchmark coverage. That is, benchmark coverage offered under a separate child health plan should differ from benchmark coverage available in the State only to the extent that the State must add coverage to the benchmark coverage, such as coverage for immunizations, to meet the requirements of title XXI.

Comment: Numerous commenters had requested clarification of when a State plan amendment is required if a benchmark plan changes. These commenters interpreted the language at § 457.20 of the proposed rule to mean that if the benchmark plan the State is using changes, we would not require a State plan amendment; whereas if the State chooses to change the coverage under its State plan to conform to the benchmark plan's changes, a plan amendment would be required. The commenters asked why changes to a State plan that simply parallel changes in a benchmark plan require an amendment given that benchmark plans are supposed to be the standard of adequacy in terms of SCHIP benefits.

Several commenters believed the preamble should be clarified to indicate that an amendment is only required when the SCHIP benefits package is altered.

Response: The approved State plan must accurately reflect the health benefits package being offered. A State must submit a State plan amendment to reflect any change in the health benefits coverage regardless of whether the change is made to conform to changes made in the benchmark plan to which the State's health benefits coverage is supposed to be equivalent, or whether the change is made to select a different health benefits coverage option. See subpart A for further discussion of when a State must submit a State plan amendment.

Comment: One commenter felt that States should not be allowed to amend their State plans to make them less comprehensive in terms of coverage or the benefits they provide. According to this commenter, State plans should only be amended to improve coverage, not to diminish it. A basic package of benefits should be required. In other words, certain benefits should be Federal entitlements. States then have the flexibility to improve that benefit package or to offer only what is Federally required.

Response: States are responsible for determining the health benefits coverage under a separate child health program subject to the standards set by title XXI and implemented in this final regulation. States have the option of choosing from the types of coverage specified in § 457.410 of the proposed rule and in accordance with section 2103 of the Act. States may amend their State plans to decrease the coverage provided as long as all of the requirements of §§ 457.410–457.490 are met, depending on the type of coverage approved in the State plan. The only services required to be covered under every separate child health program are well-baby and well-child care, immunizations according the ACIP schedule, and emergency services as defined in § 457.10.

Comment: One commenter was concerned that a State that is using the benchmark benefit package need not submit an amendment when the benchmark changes and believed this means that if the plan includes mental health services that are subsequently dropped, the State need not file a State plan amendment.

Response: If a State has elected to provide benchmark health benefits coverage that is substantially equal to coverage under a certain benefit plan, and that plan drops coverage for mental health services, the State has two options. First, the State may continue to provide coverage for mental health services as described in its approved State plan, even though the benchmark plan has discontinued this coverage. No amendment is necessary in this case. Alternatively, if the State wants to discontinue providing mental health services under its State plan, it must submit a State plan amendment to reflect the dropped coverage.

Comment: One commenter supported the preamble language on benchmark coverage being able to differ from coverage under a benchmark plan only as necessary to meet other requirements of title XXI.

Response: We appreciate the support. The commenter is correct that benchmark health benefits coverage under § 457.420 may only differ from coverage under the benchmark plan as necessary to meet title XXI requirements. For example, as noted earlier, a State may need to add coverage for immunizations in order to comply with the requirement that they be covered under every separate child health plan.

Comment: One commenter stated that the preamble indicates in discussing § 457.420(c) that ''in calculating commercial enrollment, neither Medicaid nor public agency enrollees will be counted.'' The commenter suggested that all public agency enrollees be counted as commercial enrollees when they are enrolled in a plan offered by a private sector HMO. If it is appropriate to count Federal employees as commercial enrollees, it should be just as appropriate to count any other public employees who are enrolled in the plan. Another commenter recommended that § 457.420(c) be modified to be consistent with the preamble to exclude public agency enrollees. The proposed regulation only excludes Medicaid enrollees.

Response: We agree with the comments noting that the preamble and regulation text were not consistent with respect to the calculation of commercial enrollment. We also recognize, as noted by one of the commenters, that the preamble statement that Federal employees are considered commercial enrollees, but public agency enrollees are not, merits further consideration.

After further consideration, we have decided to retain the regulatory language as proposed, that is, the health insurance coverage plan that is offered through an HMO and has the largest insured commercial, non-Medicaid enrollment in the State. Public agency employees, as well as Federal employees, may be considered enrollees for purposes of calculating commercial enrollment.

5. Benchmark-Equivalent Health Benefits Coverage (§ 457.430)

Section 2103(a)(2) of the Act provides that a State may opt to provide a benefits package with an aggregate actuarial value that is at least equal to the value of one of the benchmark benefit packages. In accordance with the statute, we proposed at § 457.430 that the benchmark-equivalent coverage must have an aggregate actuarial value, determined in accordance with proposed § 457.431, that is at least actuarially equivalent to coverage under one of the benchmark packages outlined in § 457.420.

In § 457.430 we set forth the proposed coverage requirements for States selecting the benchmark-equivalent coverage option. Under the authority of section 2103(c)(1), we proposed that a benchmark equivalent plan must include coverage for inpatient and outpatient hospital services, physicians' surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age-appropriate immunizations provided in accordance with the recommendations of ACIP.

Under the authority of section 2110(a) of the Act as implemented at proposed § 457.402, a State may provide coverage for a wide range of services. Under the authority of section 2103(a)(2)(C), we proposed that if the State provides coverage for prescription drugs, mental health services, vision services, or hearing services, the coverage for these services must have an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of service in the benchmark benefit package. In addition, we proposed that if the benchmark plan does not cover one of the above additional categories of services, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service. A State may provide services listed in § 457.402 other than the services listed in § 457.430(b) without meeting the 75 percent actuarial value test.

Comment: Two commenters believed § 457.430 is ambiguous, confusing and potentially troublesome and allows for a court to read some distinction into the redundant provisions at 457.410(b)(1) and (2) and 457.430(b)(4) about well-baby and well-child care and immunizations applying only to benchmark-equivalent coverage. To avoid such a result, the commenter suggested that HCFA strike § 457.430(b)(4) and revise subsection (b) to read as follows: ''(b) Required services. Benchmark equivalent health benefits coverage must include, in addition to the services described in § 457.410(b), coverage for the following categories of service.''

Response: We have accepted the commenter's suggestion to revise proposed § 457.430. We have also revised § 457.410((b)(2) of the regulation text to add the phrase ''age appropriate'' to immunizations in order to make it consistent with proposed § 457.430(b)(4).

Comment: One commenter is concerned because mental health services do not fall within the scope of required services under SCHIP. The commenter is particularly concerned that children in a State that initially use a Medicaid-expansion program and then move to a separate child health program will lose the EPSDT safety net for mental health services.

Response: While children receiving SCHIP services under a Medicaid-expansion program are required to be provided the full complement of EPSDT services, there is no such requirement under a separate child health program. It is true that some children with coverage for mental health services under a Medicaid expansion could lose that coverage if the State decided to switch to a separate child health program. Those children, however, would be in no worse position than if the State had originally elected a separate child health program. We have no basis to limit State flexibility by mandating benefits beyond those specifically required by the statute, however, we encourage States electing to shift from a Medicaid expansion program to a separate child health program or combination program to retain a comprehensive benefits package that is similar to the Medicaid expansion benefit package to help ensure that children do not experience a significant disruption in care.

Comment: One commenter believed HCFA should promulgate minimum benefits standards for benchmark-equivalent coverage. They noted that HCFA indicated that it has chosen not to propose minimum standards for basic sets of services because a greatly reduced benefits schedule would be unlikely to meet actuarial value requirements. However, the commenter argues that because SCHIP plans may involve much lower cost-sharing requirements than commercial plans, a SCHIP benefits package can offer far fewer services than a benchmark commercial plan and still pass actuarial muster. Accordingly, the commenter respectfully urged the Secretary to revisit this decision and promulgate minimum benefits standards for benchmark-equivalent coverage.

Response: We have considered the issue raised by the commenter but have declined to revise the regulation to set minimum standards at this time. The actuarial value requirements should ensure that the benefits in an actuarial-equivalent benefit package that will not fall below levels intended by title XXI. In fact, experience has shown that States that have chosen to provide benchmark-equivalent health benefits coverage provide coverage that looks very similar

to coverage under other health benefits coverage options.

Comment: One commenter recommended deleting § 457.430(c)(2) because benchmark-equivalent coverage should not be required to include coverage for specific services just because they are covered in the benchmark package. According to this commenter, the intent of equivalent packages is to allow a State the flexibility to design coverage that meets the needs of children in the state.

Response: The language in § 457.430(c)(2) mirrors section 2103(a)(2)(C) of the Act. Therefore, we have not adopted the commenter's suggestion to delete this material.

6. Actuarial Report for Benchmark-Equivalent Coverage (§ 457.431)

In accordance with section 2103(c)(4) of the Act, at § 457.431 we proposed to require a State, as a condition of approval of benchmark-equivalent coverage, to provide an actuarial report, with an actuarial opinion that the benchmark-equivalent coverage meets the actuarial requirements of § 457.430. We also proposed that the actuarial report must specify the benchmark coverage used for comparison.

The actuarial opinion must meet all the provisions of the statute. We proposed that the report must explicitly state the following information:

- The actuary issuing the opinion is a member of the American Academy of Actuaries (and meets Academy standards for issuing such an opinion).
- The actuary used generally accepted actuarial principles and methodologies of the American Academy of Actuaries, standard utilization and price factors, and a standardized population representative of privately insured children of the age of those expected to be covered under the State plan.
- The same principles and factors were used in analyzing both the proposed benchmark-equivalent coverage and the benchmark coverage, without taking into account differences in coverage based on the method of delivery or means of cost control or utilization used.
- The report should also state if the analysis took into account the State's ability to reduce benefits because of the increase in actuarial value due to limitations on cost sharing in SCHIP.

Finally, we proposed that the State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

Comment: We received two comments on this section. One commenter supported the requirement for a set of comprehensive actuarial reports. The second commenter suggested that the requirement for proof of actuarial equivalence of the benefits will be too costly. The commenter noted that insurance industry and State regulatory departments have developed methods of comparing coverage that would be significantly more cost effective and equally as useful for the program as an actuarial study.

Response: We appreciate the support of the first commenter. In response to the suggestion of the second commenter, the actuarial report requirements contained in this section of the regulation text are basically drawn from the section 2103(c)(4) of the Act. Therefore, we have chosen not to alter the requirements in the regulation to allow an alternative approach to benchmark equivalent coverage. However, as discussed under § 457.450, we are willing to entertain other suggestions for Secretary-approved coverage. We will consider States' specific proposals for alternatives to actuarial analysis under the provisions of § 457.450.

7. Existing Comprehensive State-Based Coverage (§ 457.440)

In accordance with section 2103(d) of the Act, at § 457.440 we proposed that existing comprehensive State-based health benefits coverage must include coverage of a range of benefits, be administered or overseen by the State and receive funds from the State, be offered in the State of New York, Florida, or Pennsylvania, and have been offered as of August 5, 1997. In essence, Congress deemed the existing State-based health benefit packages of three States as meeting the requirements of section 2103 of the Act. We noted that these States still need to meet other requirements of title XXI, including requirements relating to cost sharing, such as copayments, deductibles and premiums, as specified in subpart E of this final rule.

We also proposed that the States (Florida, New York, and Pennsylvania) may modify their existing, comprehensive, State-based program under certain conditions. First, the program must continue to offer a range of benefits. Second, the modification must not reduce the actuarial value of the coverage available under the program below either the actuarial value of the coverage as of August 5, 1997 or the actuarial value of a benchmark benefit package. A State must submit an actuarial report when it amends its existing State-based coverage.

We did not receive any comments on this section. Therefore, we are implementing these provisions as set forth in the proposed rule except that we have added language to the regulation to clarify that a State must submit an actuarial report when it amends its existing State-based coverage.

8. Secretary-Approved Coverage (§ 457.450)

Section 2103(a)(4) of the Act defines Secretary-approved coverage as any other health benefits coverage that provides appropriate coverage for the population of targeted low-income children to be covered by the program. In proposed § 457.450 we set forth the option of providing health benefits coverage under the Secretary-approved health benefits coverage option.

We proposed that the following coverage be recognized as Secretary-approved coverage under a separate child health program:

- Coverage that is the same as the coverage provided under a State's Medicaid benefit package as described in the existing Medicaid State plan.
- Comprehensive coverage offered under a § 1115 waiver that either includes coverage for the full EPSDT benefit or that the State has extended to the entire Medicaid population in the State.
- Coverage that includes benchmark coverage, as specified in § 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that it provides all the benchmark coverage, including all coverage required under title XXI, but may also provide additional services.
- Coverage, including coverage under a group health plan, purchased by the State that the State demonstrates to be substantially equal to coverage under one of the benchmark plans specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage. Under this option, if coverage for just one benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in § 457.431 to determine actuarial equivalence.

While we listed these four options as permissible types of Secretarial-approved coverage, we solicited comments on other specific examples of coverage packages that States have developed, or might wish to develop, to meet the Title XXI requirements. We also proposed that no actuarial analysis is required for Secretary-approved

coverage if the State can show that the proposed benefit package meets or exceeds the benchmark coverage. While the four options we listed meet or exceed the benchmark package, it is possible that a State may develop a Secretary-approved coverage proposal that may require an actuarial analysis.

Comment: One commenter argued that ''Secretary-approved coverage'' should provide HCFA with greater flexibility to approve SCHIP State plans. The commenter points out that Secretary-approved coverage is not simply another name for benchmark coverage; title XXI provides for Secretary-approved coverage as a flexible way for HCFA to approve a State plan. The statute requires no actuarial analysis for this option but rather requires only that the coverage be deemed ''appropriate'' for the target population.

The commenter recommended that the regulations should simply indicate that States must demonstrate, to the Secretary's satisfaction, that their coverage meets the needs of their SCHIP populations. The manner in which States make this demonstration should be left flexible in accordance with the discretion accorded to States by title XXI.

Response: The list of four examples included in the regulation text at § 457.450 was not meant to be an exhaustive list of examples of Secretary-approved coverage. The regulations text states that Secretary-approved coverage ''may include'' one of these options. We solicited additional examples of types of coverage that might qualify under this option but we did not receive any specific examples. We remain open to reviewing other proposals for Secretary-approved coverage.

Comment: One commenter noted that a number of States are exploring buy-in programs where SCHIP funds will be used to subsidize coverage for the uninsured under group health plans. A significant issue for States is how to design programs that can meet HCFA's SCHIP benefit requirements. The preamble to the proposed rule states that if any benefit under an employer plan does not meet or exceed that of a benchmark plan provided under title XXI, based on a benefit-to-benefit comparison, the State must document that the two benefit packages are actuarially equivalent. However, providing such comparisons would likely be costly and burdensome to implement on an employer-by-employer basis. The commenter strongly encouraged HCFA to modify the preamble to provide for maximum State flexibility in the area of benefit certification under buy-in programs. HCFA could provide such flexibility by allowing States more flexibility to designate benefit packages that meet the benchmark standard or to use simple benefit checklists.

Response: We recognize the administrative burden involved in determining whether employer plans meet benefit requirements for separate child health programs, and we agree that documenting the actuarial equivalence of a plan or using benefit side-by-side comparisons may be costly and burdensome. Nonetheless, employer plans through which States wish to offer coverage under a separate child health program must meet requirements for either benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage in order to comply with section 2103 of the Act. However, we are open to, and encourage States to propose other options under the ''Secretary-approved'' category.

Comment: Two commenters recommended that proposed § 457.450 should explicitly reference Medicaid benefits for children rather than permit States to furnish SCHIP children with Medicaid benefits for adults without any actuarial analysis showing comparability to standard commercial benefits. Specifically, paragraphs (a) and (b) should be consolidated and revised to read: ''(a) Coverage that is the same as the coverage for children provided under the Medicaid State plan.''

Response: While we have not adopted the exact language and consolidation recommended by the commenter, we have revised § 457.450(a) to specify that coverage should be the same as that offered to children under the Medicaid State plan.

Comment: One commenter believed the proposed rule should be amended to eliminate the use of a benefit-by-benefit comparison for determining whether coverage provided through premium assistance under a group health plan is approvable. This provision appears to require benefit-by-benefit comparison for demonstrating that group health plans meet or exceed coverage requirements. This is a more rigorous test than that required for benchmark equivalent coverage purchased directly by States. Premium assisted group health plan coverage should be held to no more than the requirements for benchmark equivalent coverage.

The commenter noted that their State experience has shown that children are more likely to be insured if their parents are insured and that parents prefer to cover their entire family under the same plan. HCFA's imposition of barriers to the use of SCHIP programs to support group health coverage is a misguided attempt to address substitution of coverage. States should be given as much flexibility as possible to test different approaches, including buy-in to employer sponsored plans, for increasing creditable coverage for uninsured children. HCFA should not add any restrictions to those already established by law in title XXI.

Response: We did not intend to impose additional restrictions on States wishing to utilize premium assistance programs in SCHIP. The benefit-by-benefit comparison was developed in response to States who wanted to provide premium assistance through employer sponsored insurance but were concerned about the cost of performing the actuarial analysis required by the statute for each participating employer plan. Therefore, we proposed that States may compare each benefit to the benefits in the benchmark plan as a way of providing States with a simplified and lower cost option to the actuarial analysis. However, given the statutory requirement for actuarial equivalence we still require that States perform an actuarial analysis if one benefit is lower than the level specified in the benchmark plan.

9. Prohibited Coverage (§ 457.470)

In accordance with section 2103(c)(5) of the Act, we proposed at § 457.470 that a State is not required to provide health benefits coverage under the plan for an item or service for which payment is prohibited under title XXI even if any benchmark package includes coverage for that item or service. We did not receive any comments on this section. Therefore, we are implementing these provisions as set forth in the proposed rule.

10. Limitations on Coverage: Abortions (§ 457.475)

This section implements sections 2105(c)(1) and (c)(7) of the Act, which set limitations on payment for abortion services under SCHIP. At § 457.475, we proposed that FFP is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services, unless the abortion is necessary to save the life of the mother or the abortion is performed to terminate a pregnancy resulting from an act of rape or incest.

Additionally, we proposed that FFP is not available to a State in expenditures of any amount under its title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other

than to save the life of the mother or resulting from an act of rape or incest.

We also proposed that, if a State wishes to have managed care entities provide abortions in addition to those specified above, those abortions must be provided pursuant to a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate to be paid with State-only funds, or append riders, attachments, or addenda to existing contracts to separate the additional abortion services from the other services covered by the contract. The proposed regulation also specified that this requirement should not be construed as restricting the ability of any managed care provider to offer abortion coverage or the ability of a State or locality to contract separately with a managed care provider for additional abortion coverage using State or local funds.

Comment: One commenter recommended that abortions be covered under any circumstances.

Response: Federal financial participation is available in expenditures for abortions in an SCHIP program only as specifically authorized by Congress in the statute. Section 2105(c)(1) of the Act limits funding of abortions to funding for those abortions necessary to save the life of the mother or to terminate pregnancies resulting from rape or incest.

Comment: We received many comments on the requirement that States that wish to cover abortions other than those allowed under the statute use separate contracts with managed care organizations to ensure that no Federal SCHIP funds are used to pay for those additional abortions. The commenters believed that this requirement exceeds the statutory authority, will be burdensome for States and managed care entities, and may ultimately serve to dissuade States and managed care entities from offering abortion services. Several commenters also indicated that enforcement of the requirement is not feasible in an employer-sponsored insurance environment where the benefits package is predetermined by an employer and a commercial insurer, rather than by the State. They recommended that employer-sponsored programs be exempt from the separate contract requirement.

Response: Section 2105(c)(7) of the Act specifies that ''payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that included coverage of abortion.'' Congressional authorities have made clear that this section of the statute requires separate contracts where managed care organizations will be providing abortions in addition to those specified in the law. Thus, contrary to the opinion of the commenters, this prohibition can not be satisfied by carving out or allocating a portion of the capitated rate to be paid for with State-only funds.

11. Preexisting Condition Exclusions and Relation to Other Laws (§ 457.480)

In proposed § 457.480 we implemented the provisions of sections 2103(f), and 2109 of the Act under the authority of section 2110(c)(6) we implemented the provisions of sections 2103(f), 2109 and 2110(c)(6). At § 457.480(a), we proposed to implement section 2103(f) of the Act and provide that, subject to the exceptions in paragraph § 457.480(a)(2), a State child health plan may not permit the imposition of any preexisting condition exclusion for covered benefits under the plan. In § 457.480(a)(2), we proposed that if the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as permitted under ERISA and HIPAA.

In proposed § 457.480(b), we implemented sections 2109 and 2103(f)(2) of the Act, which describe the relationship between title XXI and certain other provisions of law. Specifically, as set forth in proposed § 457.480(b), these provisions include section 514 of ERISA, HIPAA, the Mental Health Parity Act of 1996 (MHPA) (regarding parity in the application of annual and lifetime dollar limits to mental health benefits) and the Newborns and Mothers Health Protection Act of 1996 (NMHPA) (regarding requirements for minimum hospital stays for mothers and newborns). See regulations at 45 CFR 146.136 for a discussion of the MHPA and 45 CFR 146.130 and 148.170 for a discussion of the NMHPA.

Comment: One commenter agreed with the inclusion of language in § 457.480 requiring compliance with the Mental Health Parity Act. However, several commenters raised concerns because they interpreted the language at § 457.480(b)(3) and (4) to mean that States must comply with the MHPA and the NMHPA, regardless of whether or not the State's benchmark plan includes these components. The commenters believed this requirement negates the flexibility otherwise provided the State in choosing the option of using a separate child health plan. The commenters believed that this language should be removed from the final regulation and that States should decide if inclusion of these components in their separate child health programs is appropriate.

One commenter indicated that this requirement would require the offeror of the benchmark plan either to price a SCHIP product separately to the State, to incorporate the mental health parity costs and benefits, or to include these benefits at the same cost (an unlikely scenario). Either way, the commenter argued that the provision reduces the flexibility of using a benchmark plan and thus the proposed linkage of SCHIP to these laws is not appropriate and should be removed.

Response: We agree that the proposed regulation language was unclear and have revised the language to clarify this issue. The commenters appear to have interpreted the proposed rule to mean that States must provide coverage for mental health services and services for newborns and mothers regardless of whether a State's benchmark plan includes coverage for those services. We did not intend to impose such coverage requirements.

The requirements of the MHPA apply only to group health plans (or health insurance coverage offered by issuers in connection with a group health plan) that provide such medical/surgical benefits for newborns and mothers and mental health benefits. Thus, the provisions of MHPA apply only to title XXI coverage provided through a group health plan and only if that plan offers mental health benefits. However, if a State uses a group health plan as a benchmark, then the State may be implicitly required to comply with the MHPA even if that law is not directly applicable. Similarly, the NMHPA applies directly only to group health plans and health insurance issuers (in the group and individual markets) providing benefits for hospital lengths of stay in connection with child birth. We did not intend to impose additional coverage requirements on States or to reduce the State's flexibility in defining its service packages. We have thus revised the regulations to clarify that only group health plans through which States provide coverage under a State plan are subject to the requirements of the provisions described in §§ 457.480(b)(3) and (4).

Comment: One commenter raised the issue of HIPAA requirements and the pre-existing condition exclusions. The commenter noted that because SCHIP enrollees generally will not meet the requirements of ''eligible individuals'' under HIPAA, the level of protection

afforded by this proposed rule against pre-existing condition exclusion clauses in a SCHIP benchmark package offered by a private insurer is unclear. The proposed rule does state that SCHIP benefits are creditable coverage; however, the commenter stated that the prohibition against pre-existing condition exclusions is triggered only if creditable coverage was followed by COBRA coverage. The commenter noted that clarification of the pre-existing condition exclusion provisions will be important for health providers caring for children with disabilities.

One commenter also indicated that the regulations do not permit any ''preexisting conditions exclusions'' for a State plan in general. However, if a SCHIP plan provides coverage through a group health plan, the plan could impose preexisting conditions exclusions in accordance with what is allowable under HIPAA. While HIPAA does limit the extent of preexisting condition exclusions, States should be allowed to negotiate with health plans the elimination of all preexisting condition exclusions.

Another commenter encouraged the inclusion of a statement at § 457.480(a)(2) that while States may, in very limited circumstances, permit the imposition of a pre-existing condition exclusion consistent with applicable Federal law, States have the discretion to, and are encouraged to, negotiate group health plan coverage free of such exclusions.

Response: Section 457.480(a) of the regulation implements section 2103(f)(1) of the Act and provides that a State may not permit the imposition of a pre-existing condition exclusion, except in the case of a State that obtains health benefits coverage through payment for, or a contract with, a group health plan or group health insurance coverage, in which case the State may permit the imposition of such an exclusion to the extent permitted under HIPAA. The protection afforded to enrollees is clear; they either face no pre-existing condition exclusion or, if enrolled in a group health plan, they potentially face an exclusion that in no case can be longer than the 12 months permitted under HIPAA. The commenter correctly notes that enrollees in a separate child health program may not meet the definition of ''Federally eligible individual'' under HIPAA's individual market protections (although they may if their most recent coverage was SCHIP coverage through a group health plan and they then exhausted any COBRA or State continuation coverage offered to them). Presumably, the commenter was concerned about former enrollees wishing to purchase private, individual market coverage. Title XXI does not provide enrollees with an assurance of meeting the definition of Federally-eligible individuals under HIPAA. However, section 2110(c)(2) of the Act as implemented at § 457.410 provides that coverage meeting the requirements of § 457.10 provided to a targeted low-income child constitutes creditable health coverage. Therefore, coverage under a separate child health program will count towards the minimum 18 months of coverage required for someone to qualify as a Federally-eligible individual.

Comment: One commenter also urged States that do and do not have mental health parity statutes to include coverage for a full range of mental illness services in their State plans when they opt to develop separate child health programs.

Response: States are given flexibility in designing their benefit packages. While we encourage States to provide services for mental illness, there is no Federal requirement for a State to include this coverage under its separate child health program if it does not elect to do so.

Comment: One commenter believed the regulation should include a statement that pre-existing condition exclusions are contrary to the intent of SCHIP and unfair. Therefore, even under the limited circumstances where such exclusions are allowed, States must be required to demonstrate attempts to negotiate group health plan coverage free of such exclusions. According to this commenter, only after demonstrating that those efforts have been exhausted, should a State plan with these very limited exclusions be approved.

One commenter asserted that the HIPAA-allowable conditions for permitting a waiting period for services for a preexisting condition are adverse to the purposes of initiating coverage for children cut off from access to services precisely because they lack coverage. The commenter believed most, if not all, children should be assessed, diagnosed, and treated quickly in response to their health deficiencies. The commenter believed this is a matter for Congress to reconsider.

Response: The language in the proposed rule at § 457.480(a)(1) and (2) was included based on section 2103(f)(1) of the Act. Section 2103(f)(1)(B) clearly provides for the possibility that States providing benefits through group health plans may allow those plans to impose pre-existing condition exclusions to the extent permitted by HIPAA. One limited exception to this rule is permitted. Under § 2103(f)(1)(B) of Title XXI, if a State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance, the plan may permit the imposition of those preexisting conditions which are permitted under HIPAA. This permits the imposition of preexisting conditions consistent with the requirements of such plans when the State is providing premium assistance through SCHIP to subsidize child or family coverage under a group health plan or group health insurance pursuant to § 2105(c)(3) of the statute. Therefore, we are unable to revise this section as suggested by the commenter.

12. Delivery and Utilization Control Systems (§ 457.490)

In accordance with section 2102(a)(4) of the Act, at § 457.490 we proposed to require that State plans include a description of the type of child health assistance to be provided including the proposed methods of delivery and proposed utilization control systems. In describing the methods of delivery of the child health assistance using title XXI funds, the proposed regulation requires a State to address its choice of financing and the methods for assuring delivery of the insurance product to children including any variations. We also proposed that the State describe utilization control systems designed to ensure that children use only appropriate and medically necessary health care approved by the State or its subcontractor. We set forth examples of utilization control systems in the preamble to the proposed rule.

Comment: One commenter noted that in this section of the proposed rule, HCFA requests a description of utilization controls designed to ensure that children use only appropriate and medically necessary health care, but does not define ''medically necessary'' in any specific manner. The commenter suggested that this term be defined in the regulation and suggested language to be used in the regulation as a definition of medically necessary.

Response: As we have indicated in response to comments on § 457.420, HCFA will not define medical necessity for SCHIP. The determination of medical necessity criteria for separate child health programs is left up to each State to define.

Comment: One commenter noted that utilization controls that might be appropriate for the adult population may not be appropriate for the pediatric population. As States implement these controls, it is important that they are

appropriate for children. These controls should take into consideration children with special health care needs as well as the unique needs of children in general.

Response: The language in § 457.490(a) of the proposed rule very specifically says ''methods for assuring delivery of insurance products to the *children*.'' Section 457.490(b) provides for ''systems designed to ensure that *children* use only appropriate * * *'' (emphasis added). We believe this language, along with the language at proposed § 457.735 (now § 457.495) requiring States to assure appropriateness of care, very clearly requires that the utilization controls be appropriate for the pediatric population. If a State provides coverage for services for children with special health care needs, States would be expected to ensure appropriate utilization controls on these services also. We believe the language in paragraph § 457.490(a) requiring States to describe methods to assure delivery of services ''including any variations,'' is sufficient to address this commenter's concerns. ''Variations'' would include additional services delivered to special needs children.

Comment: We received two comments suggesting the addition of default enrollment language in the regulation. One commenter recommended that HCFA adopt language similar to the language in the Medicaid managed care proposed rule to address default enrollment under SCHIP for States that offer eligible children a choice of plans. The commenter suggested that HCFA require that States describe in their plans the policies and procedures that they will use to minimize rates of default enrollment and what efforts the State and its contractors will make to preserve traditional provider-patient relationships. The commenter also recommended that this section include an additional paragraph:

> Describe policies and procedures that minimize rates of default enrollment where beneficiaries have a choice of plans, and what efforts have been made by the State and its contractors to preserve existing provider/patient relationships. States must also describe opportunities for beneficiaries to disenroll both for cause or on a periodic basis without cause.

Response: Default enrollment, also referred to as auto assignment, is a practice utilized by several States in their enrollment processes. However, we believe that any information or requirements regarding managed care enrollment procedures, including default enrollment, should be addressed as part of the requirements of § 457.110(a), rather than in this section.

Comment: One commenter supported the language in this section and indicated that this sets out a helpful framework that encourages States to ensure that utilization controls limit costs without denying essential health care to children.

Response: We appreciate the commenter's support.

Comment: One commenter recommended that § 457.490(a) be modified to be applicable not only to the delivery of the insurance products but also to delivery of services covered by the product.

Response: We have adopted this suggestion and revised the regulation text accordingly.

Comment: Two commenters recommended that this section be modified to require State plans to identify methods the States will use to monitor and evaluate delivery and utilization control systems to ensure that children receive appropriate and medically necessary care.

Response: Proposed § 457.735 (now § 457.495) addresses State plan requirements for assuring quality and appropriateness of care provided under the plan. Please see our responses to comments in that section.

13. Grievances and Appeals (Proposed § 457.495)

At § 457.495, we proposed to require States to provide enrollees in a separate child health program with the right to file grievances or appeals for reduction or denial of services in accordance with proposed § 457.985. In an effort to consolidate all provisions related to review processes, we have removed proposed § 457.495 and incorporated those provisions into new subpart K, which contains provisions regarding grievances and appeals. We address comments on proposed § 457.495 in new subpart K.

14. State Plan Requirement: State Assurance of the Quality and Appropriateness of Care (§ 457.495)

Sections 2102(a)(7)(A) and (B) of the Act require the State plan to describe the strategy the State has adopted for assuring the quality and appropriateness of care, particularly with respect to providing well-baby care, well-child care and immunizations, and for ensuring access to covered services, including emergency services. We proposed to implement this provision at § 457.735(a), and provided further specifications therein consistent with this statutory requirement.

We also proposed to include additional, more specific assurances designed to ensure the quality and appropriateness of care for particularly vulnerable enrollees. In § 457.735(b), we proposed that States must provide assurances of appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions, including access to specialists.

In this final rule, we are redesignating the provisions of proposed § 457.735 (which were previously located in subpart G, Strategic planning) as § 457.495. We believed that these provisions are more appropriately presented in the context of this subpart. We respond to all public comments on proposed § 457.735 below.

Comment: We received several comments indicating that this section of the proposed rule was unclear as to whether the requirement for State assurance of quality and appropriateness of care applies to SCHIP coverage provided through employer plans. Commenters indicated that the requirements of the proposed regulation seem tacitly to assume that the State will have a direct, contractual relationship with all SCHIP participating health plans, including employer-sponsored plans. A commenter further stated that any attempt to apply such requirements directly to employer-sponsored plans would mean that no employer plans will ever qualify for the State's premium assistance under SCHIP, as there is no incentive for an employer or plan to invest resources to comply with these requirements. Commenters indicated that employer-sponsored health coverage systems do not identify individuals who can be classified into such categories as ''enrollees with special or complex medical conditions,'' making it difficult to report on these subgroups.

Response: We understand the commenters' concerns and desire that data reporting requirements under SCHIP are able to work within the systems and regulatory structure for premium assistance programs. The provisions of this regulation section do apply to such coverage because the statute contains no exemptions from its reporting requirements for SCHIP coverage offered through premium assistance programs. However, the regulation does not require States to report encounter data in measuring their progress toward meeting performance goals. We encourage States to use a variety of methods to collect appropriate data. While requiring plans to report encounter data to the State is one means of gathering these data, it is by no means the only method. For example, States can rely on mail or telephone surveys of

participating families and surveys of participating providers, or can design a data collection methodology that works with the structure and offerings of their SCHIP programs, including those operating premium assistance programs.

Comment: We received comments recommending that we require specific reporting requirements for States offering premium assistance programs through group health plans.

Response: States that implement or design premium assistance programs for SCHIP have flexibility to explore different methods of working with employers, health plans and beneficiaries to obtain information on SCHIP coverage provided through group health plans. Because of the difficulty of obtaining data from employer plans with which the State may not have direct contractual relationships, we intend to continue to work with States exploring the implementation of premium assistance programs and will continue to consider a variety of State proposals regarding appropriate methods of obtaining information about the quality of care obtained through premium assistance programs.

Comment: We received comments that the regulation should allow States the flexibility to use strategies that employers already have in place, or to use alternative strategies, to ensure quality and appropriateness of care.

Response: First, it should be noted that, upon further reflection, we have determined that the provisions and intent of proposed § 457.735 would fit more appropriately within Subpart D, Benefits. The focus of this provision is to ensure that SCHIP enrollees have adequate access to health care services as needed. Therefore, we have moved the comments and responses on this provision to Subpart D, § 457.495.

We agree that, pursuant to the provisions of title XXI, States should have the flexibility to use innovative strategies to ensure quality and appropriateness of care. Section 457.495(a) provides that States must provide HCFA with a description of the methods that a State uses for assuring the quality and appropriateness of care provided under the plan. We did not specify a particular method States must use to monitor appropriateness and quality of care. We anticipate that States will use a variety of methods, including those most suitable for the type of program or programs a particular State is implementing.

Comment: Several commenters recommended that we establish specific, unified, quality and access standards with respect to those areas set forth in § 457.495 and identify the methodologies for monitoring those standards in the regulations. Several commenters recommended that we require States to describe methods they will use to ensure that children have access to pediatricians and other health care providers with expertise in meeting the health care needs of children. The commenters felt that physicians who are appropriately educated in the unique physical and developmental issues surrounding the care of infants, children, young adults and adolescents should provide children's care. As the SCHIP program is specifically designed to serve children, commenters noted that it is critical that access to appropriate providers of care be required. One commenter recommended the annual application of a standardized survey of children's mental, physical, and social health.

Response: Section 457.495 requires that a State describe the specific elements of its quality assurance strategies. These may include the use of any of the following methods: quality of care standards; performance measurement, information and reporting strategies, licensing standards, credentialing/recredentialing processes, periodic reviews and external reviews. We are not requiring that States meet specific, unified standards regarding access to and quality of care. However, the regulation at § 457.495 does requires States to assure the quality and appropriateness of care provided under the State plan. As part of the State's assurances, each State agency would be expected to assure that all covered services are available and accessible to program enrollees. This means that all covered services would be available within reasonable time frames and in a manner that ensures continuity of care, adequate primary and specialized services, and access to providers appropriate to the population being served under the SCHIP plan. We believe this assurance is sufficient to address the concerns of the commenters.

Comment: One commenter recommended that quality of care standards reflect professional judgment and local standards of care as distinguished from standards of care developed by third-party payers or fiscal intermediaries.

Response: We encourage States, as they create methods of assuring and evaluating quality of care provided to SCHIP participants, to take into consideration sources of quality of care standards and to make a determination about whether to incorporate standards endorsed or used by local providers, national provider associations, national health research institutes, or health insurance or managed care organizations into their State plan.

Comment: Several commenters supported the requirement in § 457.735(a) that States describe methods of assuring the quality and appropriateness of care under SCHIP, particularly with regard to well-baby and well-child care, immunizations, and access to specialty care. One commenter suggested that HCFA use the phrase ''access to specialty services'' rather than the phrase ''access to specialists'' in § 457.735(b).

Response: We considered the commenters' suggestion and concluded that modifying the term ''access to specialists'' with the clarification of ''access to specialists experienced in treating the enrolled's medical condition'' would provide broader assurances that the children identified in § 457.495(c) would have access to the appropriate specialty services. Therefore, we have revised § 457.495(c) accordingly.

Comment: We received several comments applauding the inclusion of well-adolescent care with well-child care in the quality assurance requirements at § 457.495. Commenters suggested including the word ''adolescent'' in the definition of well-baby and well-child services and using the term in connection with well-child care throughout the regulation. The commenters indicated that they believe we should focus on the unique health needs of adolescents, which make up approximately 39 percent of SCHIP eligible youth, because their health needs differ from those of younger children. The commenters also urged HCFA to list specifically in the regulation medical sources that have guidelines for infants, children and adolescents. In these commenters' view, these sources should include the American Academy of Pediatrics' ''Guidelines for Health Supervision of Infants, Children and Adolescents,'' the American Medical Association's ''Guidelines for Adolescent Preventive Services,'' and the American College of Obstetricians and Gynecologists' ''Primary and Preventive Health Care for Female Adolescents.''

Response: We appreciate the commenters' support of our emphasis on assuring the quality and appropriateness of care for children and our specific reference to certain types of adolescent care. While understand the view that this emphasis is important at § 457.495, because of our concern for assuring quality and appropriateness of care, we have not adopted the commenters suggestion with respect to using this terminology throughout the

rest of the final rule. The definition of child for purposes of SCHIP at § 457.10 and section 2110(c)(1) of the Act indicates that a ''child'' is an ''individual under the age of 19.'' Adolescents within this age range are clearly included in this definition and therefore we have not included the term in other references to well-baby and well-child care. Because we are not requiring that States adopt specific standards of care, we are not including the commenters' list of sources in the regulation text. We are including the commenters' listing here in the preamble so that States may consider these sources as recommendations in developing their own standards.

Comment: One commenter noted that accreditation is a method widely used by commercial purchasers to assure the quality of care provided by health plans. The commenter noted that accreditation, a comprehensive assessment of the quality of a health plan, is particularly useful in assessing the effectiveness and timeliness of procedures used to monitor and treat enrollees with serious medical conditions. The commenter urged HCFA to acknowledge that a State using HEDIS (Health Plan Employer Data and Information Set) measures would meet the State plan requirements set forth in this section. The commenter noted that HEDIS includes measures that specifically address the elements of care within SCHIP including:

—Childhood and adolescent immunizations;
—Use of appropriate medications for people with asthma;
—Children's access to primary case managers (PCPs);
—Annual dental visits;
—Well child visits in the first 15 months, third, fourth, fifth, and sixth years of life;
—Adolescent well visits;
—Ambulatory care;
—Inpatient utilization;
—Ratings of personal doctor, nurse, specialist;
—Rating of health care;
—Rating of health plan;
—Getting needed care and getting care quickly;
—How well doctors communicate;
—Courteous and helpful staff; and
—Customer service and claims processing.

Response: States have flexibility in determining the State-specific performance measures they will use in determining quality and access to care. In making these determinations, States have the ability to utilize those data collection tools and analysis methodologies that are most suited to the circumstances of their SCHIP program. HEDIS is one of several tools we recommended in the proposed regulation that States consider as they design ways of measuring appropriateness and quality of care in SCHIP, but there may be other tools States may wish to consider. Specifically, in the preamble to the proposed rule, we recommended that States refer to several tools including the Consumer Assessments of Health Plans Study (CAHPS), the U.S. Preventive Services Task Force Guidelines, Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, and the Office of Disease Prevention and Health Promotion's Health People 2000 and Healthy People 2010.

Comment: One commenter cautioned HCFA that while HEDIS is a widely accepted and adopted collection system, it has limitations in its usefulness for monitoring performance under SCHIP. The commenter urged HCFA to work with NCQA to understand these limitations and the explore ways to address them. Additionally, the commenter encouraged HCFA to include the American Academy of Pediatrics Guide for Health Supervision III to the list of standards, benchmarks, and guidelines states should look to for performance measures.

Response: We agree that the suggested performance measure guidelines mentioned in the preamble to the proposed rule all have certain limitations that the States should take into consideration as they develop strategies for measuring performance goals related to their strategic objectives. Additionally, we encourage States to consider the American Academy of Pediatrics Guide for Health Supervision III in developing their performance measures.

Comment: Commenters recommended that we require States to include procedures to monitor the extent to which the program has sufficient network capacity, including providers and specialists who serve the particular needs of the adolescent enrollees, both male and female, and provides services such as women's health services, family planning and transitional services. According to these commenters, the monitoring should include measures relevant to the care of adolescents, (annual well-adolescent visits, adolescent immunization rates, etc.) and immigrants, and access to services without unreasonable delay.

Response: We have not adopted the commenters' suggestions. Section 457.495 requires States to include in the State plan a description of the methods that a State uses for assuring the quality and appropriateness of care and for ensuring access to covered services provided under an SCHIP plan. It is therefore, not appropriate to include a list of specific types of services, specialists, or groups; and risk unintentionally excluding an area that also needs attention. However, we did include language regarding access to specialists in general in order to emphasize the need for such access. We have also required States to provide a decision regarding the authorization of health services within 14 days of the service being requested. A possible extension to this 14 day period may be granted in the event that the enrollee requests an extension or the physician or the health plan determines that additional information is required. All such decisions must be made in accordance with the medical needs of the patient. The language of section 457.495 as finalized, allows us to address the concerns of the commenters while allowing States the flexibility the SCHIP statute provides them.

Comment: One commenter indicated that it was difficult to determine the applicability of the requirement to assure appropriate and timely procedures to monitor and treat enrollees with complex and serious medical conditions for fee-for-service programs. The commenter believed that the quality of care monitoring requirement in § 457.495(a) is sufficient to protect enrollees and that the requirement at § 457.495(b) regarding complex and serious medical conditions should be eliminated.

Response: We disagree with the commenter. Because of the importance of ensuring that children with chronic, serious or complex medical conditions receive continuous and appropriate care, with the ability to access specialists as often as needed, particular attention is necessary in specifying the requirement at § 457.495. We understand that it is more difficult for States to implement this requirement in the fee-for-service sector than it would be in a managed care environment. However, in order to assure quality care to participants with chronic, serious or complex medical conditions, it is essential that States provide specific assurances that they have established appropriate procedures to monitor and treat these participants whether they are enrolled through fee-for-service programs or through MCEs. Therefore, we have retained the requirement at § 457.495(b), as revised.

Comment: One commenter urged HCFA to require the States to describe

procedures for providing case management to those with complex and serious medical conditions. The commenter believed that quality of care for those with complex medical conditions is greatly enhanced by case management. The commenter also urged HCFA to require States' to include appropriate peer review by pediatricians and appropriate pediatric specialists in their quality assurance mechanism.

Response: While States may want to establish procedures for providing case management to enrollees with chronic, complex or serious medical conditions to enhance quality and access to care for those participants, we have not required all States to use that particular method to assure quality and appropriateness of care. We note that case management is one service that States may, but are not required to, provide under § 457.402. However, other methods to assure quality and appropriate care are also acceptable and may be just as effective, depending upon the design of the State's SCHIP.

Comment: One commenter suggested that we revise § 457.495(b) as follows: ''States must assure appropriate and timely procedures to monitor and treat enrollees with complex, serious or chronic medical conditions (including symptoms) including access to appropriate pediatric, adolescent and other specialists and specialty care centers and must assure that children with complex, serious or chronic medical conditions receive no lower quality of care than received by children with special health care needs served by the State's programs under title V of the Social Security Act.''

Response: We will modify the phrase ''complex and serious'', to add the term ''chronic'', as suggested by the commenter. In addition, to provide further flexibility, we are changing the word ''and'' to ''or''; and the phrase will be written as, ''chronic, complex or serious''. We believe this phrase encompasses the symptoms of these enrollees, making further specification unnecessary. We have also revised the requirement for access to specialists within that provision to read, ''access to specialists experienced in treating the specific medical condition* * *'' We believe the addition of these terms in § 457.495(b) assures that SCHIP programs will adequately serve the health needs of enrollees with chronic, complex or serious medical conditions, by assuring that children with these conditions will have access to care from specialists most adequately suited to meet the child's needs. Since States have the flexibility to establish their own standards for assuring appropriate treatment and quality of care, we do not agree with the commenter's suggestion that we should specify the inclusion of specialty care centers or particular standards of care.

Comment: One commenter mentioned several times throughout its comments that access to dental services is a problem under Medicaid and that HCFA should take action to correct this problem.

Response: While Medicaid coverage of dental services is not the subject of this regulation, we would like to bring to the attention of the commenter the HCFA/HRSA Oral Health Initiative (OHI) which is an ongoing effort to improve access to high quality oral health services for vulnerable populations, particularly children enrolled in Medicaid and SCHIP. HCFA teamed with HRSA almost two years ago and initiated the OHI in a effort to bring together Federal staff, State Medicaid agencies and national, State and local level dental organizations to recognize and address this issue. Both HCFA and HRSA recognize that resolving barriers to oral health access in Medicaid and SCHIP must begin with the understanding that Medicaid and SCHIP are programs that rely upon Federal-State partnerships: the Federal government provides broad guidelines under which States implement individual programs. Both HCFA and HRSA believe that solutions to oral health disparity in Medicaid and SCHIP will most likely be found at the local and State levels. Both agencies seek to provide resources, guidance and technical assistance necessary to enable States and localities to better address their local oral health concerns.

Some activities that have been undertaken by the OHI include: co-sponsoring a national leadership conference that brought together for the first time the State Medicaid and State Dental Directors with the leadership of the dental profession; collaborating with the private sector (that is, the American Dental Association convened a second national leadership conference for stakeholders to continue the progress and dialogue achieved in the first meeting and also to include State legislators in the process); supporting State dental summits/workshops to provide the opportunity for State level players to meet with each other on a face-to-face basis to address oral health problems specific to their States and develop State-specific strategies and implementation plans; promoting best practices by providing State dental officials the opportunity to share common dental concerns and potential best practices by initiating and supporting a privately managed electronic list serve which connects, for the first time, Medicaid program officials in each State with each other, and with State health officials and the Federal OHI team. Discussion of further activities undertaken by HCFA and the OHI to improve the oral health of this vulnerable population is contained in the Department responses to the April 27, 1999 report of the General Accounting Office (GAO), ''Oral Health: Dental Disease is a Chronic Problem Among Low-Income Populations.'' This report is available from the GAO web site at *www.gao.gov.*

Finally, in an effort to focus attention on the oral health issues and to build an oral health infrastructure, HCFA has appointed a full-time Chief Dental Officer to serve as a focal point for oral health issues and has identified staff in each HCFA Regional Office to serve as Medicaid dental coordinators.

Comment: Several commenters suggested that the regulation include language to specifically require access to various types of providers, such as, pediatric and adolescent specialists, and obstetricians/gynecologists. In addition, one commenter suggested that State plans should be required to assure that female adolescents have direct access to women's health specialists and that pregnant adolescents be permitted to continue seeing their treating provider through pregnancy and the post-partum period in instances where the contracting plan or provider has left the SCHIP program.

Response: We have not adopted the commenters' suggestions. Section 457.495 requires that the State plan include assurances of the quality and appropriateness of care and services provided under a State plan including treatment of chronic, serious or complex medical conditions and access to specialists. This requirement addresses the concerns of the commenters while allowing States the flexibility to establish the means by which they will assure access to appropriate care that the SCHIP program provides them. This regulation requires States to ensure access to providers appropriate to the population being served under the State plan.

Comment: Two commenters recommended that we revise the regulation to provide that a State and its participating contractors must provide services as expeditiously as the enrollee's health condition requires. The commenter also suggested time frames of approval of a request for services within seven calendar days after receipt of the request for services, with a possible extension of fourteen days. The

commenters also recommended an expedited time frame if the physician indicates, or the State/contractor determines that following ordinary time frames could seriously jeopardize the enrollee's life or health or ability to regain maximum function, to be no later than 72 hours after receipt of the request for services, with a possible extension of up to 14 additional calendar days. Another commenter suggested requiring a response within seven days to an initial request for service or within 72 hours for an expedited procedure.

Response: We recognize the commenters' concerns and have addressed these issues in new subpart K, Applicant and Enrollee Protections, at § 457.1160.

E. Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

1. Basis, Scope, and Applicability (§ 457.500)

A State that implements a separate child health program may impose cost-sharing charges on enrollees. A State that chooses to impose cost-sharing charges on enrollees must meet the requirements described in section 2103(e) of the Act. In proposed § 457.500, we set forth section 2103(e) of the Act as the statutory basis for this subpart, containing cost-sharing provisions. As proposed, this subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges. We proposed that these provisions apply to all separate child health programs regardless of the type of coverage (benchmark, benchmark equivalent, Secretary-approved or existing comprehensive State-based coverage) provided through the program.

We noted in the preamble that these requirements apply when a State with a separate child health program purchases family coverage for the targeted low-income child under the waiver authority of section 2105(c)(3) of the Act and proposed § 457.1010 and when a State provides premium assistance for coverage under a group health plan as defined in § 457.10. We proposed that this subpart does not apply to Medicaid expansion programs. In this final rule, we revised the statutory basis at § 457.500(a) to include section 2101(a) of the Act, which describes that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Comment: A number of commenters noted that the numerous protections written into the Medicaid statute were not written into the SCHIP statute because Congress clearly recognized that these populations are different and intended that they be treated differently. The commenters noted that cost-sharing gives working families a sense of pride in sharing the cost of medical services, just like their friends, neighbors, and relatives who have employer-based insurance. They also indicated that asking families to track their own cost-sharing expenditures contributes to the development of self-sufficiency. Some commenters noted that establishing low levels of cost-sharing will encourage substitution of coverage.

Response: We have implemented §§ 457.500 through 457.570 of the final regulation under the authority of section 2103(e) of the Act. Congress included cost-sharing protections for children covered under SCHIP through separate child health programs, in recognition of the important role that affordability plays in determining whether a child has access to health care insurance and essential health care services for their families. High cost-sharing charges could result in low-income families choosing to remain uninsured, dropping insurance coverage, or avoiding utilization of necessary health care services. Increased cost sharing may also encourage enrollees to access health care only during times when care is most expensive (that is, during emergency or critical health care situations). We have retained States' ability to rely on a methodology for tracking cost sharing that places some of the responsibility on the enrollee. As noted in the preamble to the proposed rule, we do, however, encourage the use of more formal tracking mechanisms that ease any tracking or administrative burden on enrollees and providers, such as a swipe card. While we recognize that low levels of cost sharing may encourage substitution, States must meet the requirements in subpart H, Substitution of Coverage, that are intended to limit the occurrence of substitution.

Comment: One commenter suggested that HCFA revise this section to apply the SCHIP copayment rules to Medicaid expansion programs, not just separate child health plans. The commenter believed that this revision would effectuate Congressional intent, which was to allow States flexibility in implementing SCHIP plans.

Response: Section 2103(e)(4) of the Act provides that the cost-sharing requirements and limitations established pursuant to section 2103(e) do not affect the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in a Medicaid expansion program under section 2101(a)(2). Therefore, Congress has made it clear that these cost-sharing provisions were intended to apply to separate child health assistance programs only. The title XIX cost-sharing rules apply to Medicaid expansion programs, and these rules generally prohibit cost sharing for children. Therefore, the reference to Medicaid expansion programs in § 457.500(c) has been removed.

Comment: One commenter recommended that we include language in the preamble advising States that they must ensure that cost-sharing requirements are administratively workable and not unduly burdensome for managed care entities.

Response: We agree with the commenter. States should strive to impose cost-sharing charges in a manner that eases administrative burden on managed care entities and their participating providers and thereby promotes provider participation in SCHIP. We believe the cost-sharing provisions in §§ 457.500 through 457.570 of this final rule provide States with flexibility to use a variety of strategies to implement these requirements while at the same time providing enrollees with important protections.

2. General State Plan Requirements (§ 457.505)

Section 2103(e)(1)(A) of the Act specifies that a State plan must include a description of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Section 2103(e)(1)(A) also specifies that any such charges be imposed pursuant to a public schedule. In accordance with the statute, at § 457.505, we proposed that the State plan must include a description of the amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed. We further proposed that the State plan include a description of the methods, including the public schedule, the State uses to inform enrollees, applicants, providers, and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts.

We also proposed that States that purchase family coverage or offer premium assistance programs must describe how they ensure that enrollees are not charged for copayments,

coinsurance, deductibles, or similar fees for well-baby and well-child care services and that they do not charge American Indian/Alaska Native (AI/AN) children cost sharing. We also proposed that a procedure that primarily relies on a refund given by the State to implement the requirements of this subpart is not an acceptable procedure. We proposed that in States that purchase family coverage or establish premium assistance programs, the State also must describe in its State plan the procedures used to ensure that enrollees are not charged cost sharing over the cumulative cost-sharing maximums proposed in § 457.560. We emphasized that this process must not primarily rely on a refund for cost sharing paid in excess of the cumulative cost-sharing maximum. In § 457.505, we have added a paragraph (c) that will require States to include in the State plan a description of the disenrollment protections required under § 457.570. We have also added paragraph (e) in this section to reduce redundancy and more clearly identify the State plan requirements when a State uses a premium assistance program.

Comment: Several commenters did not agree with the statement in the preamble that suggested that providers could bill the State directly, so that enrollees are not inappropriately charged for certain services. They noted that many health plans are not willing to make the administrative changes necessary to bill the State agency instead of the enrollee and, in light of the difficulties, proposed that a refund component be a valid option.

Response: We disagree. States should establish adequate procedures to ensure the requirements for cost-sharing charges are met and to educate both the provider and the enrollee regarding cost-sharing obligations. Having providers bill the State directly is one option States may use as part of these procedures. We also note that we have not prohibited the use of refunds in all circumstances, but we do require that a State not use a refund as the primary method for assuring compliance with cost-sharing prohibitions and cumulative cost-sharing maximums. Other examples of tracking procedures include informing enrollees that they are approaching the cumulative cost-sharing maximum right before the cap is reached, or sending monthly letters to providers to inform them of which enrollees do not need to pay copayment amounts as of a certain date. We have revised proposed section § 457.505(d) to clarify that when States provide premium assistance for group health plans, cost-sharing charges are not permitted for well-baby and well-child care services; cost sharing is not permitted for AI/AN children; and enrollees must not be charged cost sharing that exceeds the cumulative cost-sharing maximum. These provisions must be described in the State plan. Finally, the provision specifying that ''a procedure that primarily relies on a refund given by the State for overpayment by an enrollee is not an acceptable procedure for purposes of this subpart'' has been moved to § 457.505(e) for clarity.

Comment: One commenter suggested that we define the word ''primarily'' as used in § 457.560 for a variety of situations. For example, they indicated that a State may not be able to ascertain at the time of eligibility determination whether an applicant is an AI/AN due to the lack of verification of AI/AN status on the part of the applicant and/or the lack of cooperation in verification on the part of the tribe. In this situation, the State may not waive cost-sharing charges for the individual and, in their view, the only way a State could comply with the requirement that the AI/AN population be excluded from cost sharing would be to use a procedure of refunds for overpayments, once AI/AN status was verified.

Response: We realize that there may be unforeseen circumstances when an enrollee has paid cost sharing that either should not have ever been charged or is in excess of the cost-sharing limits. In these cases, refunds will be necessary. However, refunds should not be the State's only or ongoing method to ensure that cost sharing does not exceed the regulatory limits. The State should inform each enrollee of the precise amount of the cumulative cost-sharing maximum based on the enrollee's individual family income at the time of enrollment and/or reenrollment or, in the case of a set out-of-pocket cap, inform the enrollee of cost sharing as required under § 457.525. Rather than rely on a refund mechanism, the State should educate the enrollee regarding the cumulative cost-sharing maximum and when not to pay cost sharing for the applicable time period. In the case of the AI/AN population, States should provide accessible information to the population about the State requirements for demonstrating AI/AN status and, as in other instances, seek to minimize the use of refunds as a method for compliance with the cost-sharing requirements of Subpart E.

3. Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements (§ 457.510)

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed pursuant to a public schedule. At § 457.510 we proposed that when a State imposes premiums, enrollment fees, or similar fees on SCHIP enrollees, the State plan must describe the amount of the premium, enrollment fee, or similar fee, the time period for which the charge is imposed, and the group or groups that are subject to these cost-sharing charges. We also proposed that the State plan include a description of the consequences for an enrollee who does not pay a required charge. We noted in the preamble that the State should indicate enrollee groups that are exempt from any disenrollment policy.

In addition, proposed § 457.510 set forth the requirement that the State plan include a description of the methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in proposed § 457.560, pursuant to section 2103(e)(3)(B) of the Act. We noted in the preamble to the proposed rule that the State's methodology should include a refund for an enrollee who accidentally pays more than his or her cumulative cost-sharing maximum. We proposed that a methodology that primarily relies on a refund by the State for cost-sharing payments made over the cumulative cost-sharing maximum will not be an acceptable methodology.

We discussed the findings of the George Washington University study on the types of methods States and private insurance companies use to track cost-sharing amounts against an enrollee's out-of-pocket expenditure cap. We described several examples of methods States could use to ensure that enrollees do not exceed the cumulative cost-sharing maximum. We solicited comments on tracking mechanisms States can use that do not place the burden of tracking cost-sharing charges on the enrollee.

Comment: Two commenters specifically urged HCFA to encourage States to adopt cost-sharing provisions for premiums, enrollment fees, and similar fees, as opposed to cost-sharing charges related to the provision of services (copayments, coinsurance, deductibles, or similar cost-sharing charges). The commenter asserted that applying cost sharing to premiums

instead of services would avoid the tracking burden altogether.

Response: We agree that it would be easier to track cost sharing if the State only imposed premiums or enrollment fees and that this would relieve States from the burden of tracking cost sharing associated with services. However, the statute provides States with flexibility to design cost sharing that meets their policy goals. While some States may wish to design cost sharing in a way that avoids or minimizes the need for tracking, others may favor the use of copayments to discourage over-utilization. We therefore encourage States to consider the ease of tracking along with many other factors in devising their cost-sharing systems, but do not prescribe or recommend a specific cost-sharing design.

Comment: One commenter recommended that HCFA revise paragraph (d) of this section to require that State plans include a description of the disenrollment protections established pursuant to § 457.570, in addition to the consequences for an enrollee who does not pay a charge. The commenter noted that § 457.570 requires disenrollment protections; however, nothing in the regulation currently requires States to describe these processes in the State SCHIP plan.

Response: We agree with this comment. We intended to require States to include disenrollment protections in their State plans, as stated in the preamble to the proposed regulation. Therefore, we have revised § 457.510(d) and § 457.515(d) to include the State plan requirement that States provide a description of their disenrollment protections as required under § 457.570.

Comment: Several commenters indicated that HCFA should require, rather than recommend, that States develop tracking mechanisms that do not rely on the beneficiary demonstrating to the State that he or she has met the cumulative cost-sharing maximum. The commenters did not believe that the finding of the George Washington study (that States were not charging high enough cost-sharing to make it likely that families reached their cap) was good cause for a weaker standard. The commenters noted that States are currently experiencing very good budget climates that are likely to weaken at some point, perhaps causing States to raise their cost-sharing requirements. They also observed that expansion to higher income eligibility groups may cause States to increase cost sharing under SCHIP. Moreover, the commenters believed that all States could develop the capability to track enrollees' cumulative cost sharing if required, since some States do so currently. And the commenters urged that the requirement be imposed on States and contracting plans rather than individual providers, since such a responsibility could deter provider participation in SCHIP.

Response: As part of the study conducted by George Washington University, States were invited to a meeting to discuss tracking of cost sharing under SCHIP. During this discussion, HCFA noted that some States were capable of using sophisticated tracking mechanisms like swipe cards to track their cost sharing. These States typically have a large concentration of managed care entities with participating providers who already have in place hardware that aids in tracking cost sharing for the SCHIP population. However, States with providers located in rural areas, and with providers who are not part of managed care networks, have indicated that it is administratively expensive to require States to put in place a sophisticated swipe card mechanism that would track cost sharing. Therefore, we have decided to continue to encourage States to use a tracking mechanism that does not rely on the enrollee, but will not require such a tracking mechanism due to implementation challenges and resource limitations in different States.

States must distribute, as part of the information furnished consistent with §§ 457.110 and 457.525 and general outreach activities, materials that inform the enrollee regarding his or her cost-sharing obligations, and assist the family in keeping track of the charges paid. At a minimum, States are required to include the schedule of cost-sharing charges, and the dollar amount of the enrollee's family's cumulative cost-sharing maximum. We also recommend that States educate the enrollee's family regarding tracking cost sharing against the cumulative cost-sharing cap.

Comment: Several commenters disagreed with our provision at § 457.510(e) that ''a methodology that primarily relies on a refund given by the State for overpayment (of cost sharing) by an enrollee is not an acceptable methodology.'' These commenters indicated that the use of a refund process can be the most cost effective and simple approach to ensuring that cost sharing does not exceed limits, or that individuals exempt from cost sharing are not required to pay when it is not appropriate. The commenters believe States should be given the flexibility to develop their own process as long as the process guarantees that families will not have to pay cost-sharing charges for which they are not responsible. The commenters suggested that we consider that States are limited to a 10 percent cap on administrative costs, and that overly prescriptive measures added to administrative costs can take away from other important administrative functions, such as outreach and eligibility determinations. Several commenters also questioned how these provisions apply to a State that administers SCHIP through employer-sponsored health insurance plans.

Response: As stated in an earlier response, we recognize that there are situations in which the use of a refund methodology may be necessary. However, we believe States generally must be proactive and provide specific procedures for enrollees and their families to follow so that they are not overcharged cost sharing. A State methodology that merely reimburses or refunds enrollees for any cost sharing in excess of the cumulative cost-sharing maximum without including steps to help enrollees avoid overpayment will require the enrollees to outlay cash to obtain access to services that they should have been able to access without the burden of cost sharing. We view such a refund policy to be contrary to the limits on cost sharing set forth in section 2103(e) of the Act.

Comment: One commenter suggested that we revise this section to require that, in describing the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximum, the State plan must describe how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximum. The commenter noted that the preamble stated that the description of the methodology must explain these areas. The commenter asked that this language be incorporated into the regulation.

Response: We agree with the general point that the commenter was making, that States should be required to disclose the principles used to calculate cumulative cost sharing maximums, but we believe such disclosure is equally important on an individual level as on a statewide level. Thus, we are adding paragraph (d) to 457.560, to require that the States provide the enrollee's family the precise dollar amount of the cumulative cost-sharing maximum at the time of enrollment and at the time of re-enrollment. However, we have not revised § 457.510 because it already requires the State plan to describe the methodology for ensuring that cost sharing for a family does not exceed

cumulative maximums, and this must include the information described above. If the description submitted in a proposed State plan or amendment does not include a full explanation of how income is calculated for purposes of the cumulative cost sharing maximum and other relevant details, HCFA requests this information in reviewing the submission.

Comment: One commenter stated that, if a family must pay more than the customary rate for child care due to the special needs of the child, there should be a mechanism for that additional cost to be considered when determining financial status. Children with chronic conditions should be defined to include children with mental health and substance abuse conditions. Another commenter agreed with the finding of the George Washington study that children with chronic conditions or special needs often have expenses for related, non-covered services, which can create a tremendous financial burden for the family. The commenter recommended that the statute be changed to eliminate the cost-sharing provision for eligible children with chronic illness or other special needs. In this commenter's view, at a minimum, all related expenses should be counted toward the cumulative cost-sharing cap for these children. The commenter also agreed with the George Washington study's recommendation that States assign a case manager to children with chronic needs to assure that cost sharing does not exceed the cumulative cost-sharing maximum for these children.

Response: Title XXI does not include any special provision regarding cost sharing for children with special needs or chronic conditions and we appreciate the commenter's recognition that this issue is driven by the statute. States may consider the additional costs, including the costs associated with child care and case management, borne by families of children with special needs or chronic conditions when imposing cost sharing on this population, but HCFA does not have statutory authority to require that States take these costs into account. In addition, States may, at their option, exempt families of children with special needs or chronic conditions group from cost sharing, because the added costs of care can significantly reduce their disposable income. However, we have not specifically required States to exempt these children, and have therefore not included the commenter's recommendation in the regulation text.

Comment: Several commenters opposed our suggestion in the preamble that States count non-covered services towards the cumulative cost-sharing maximum.

Response: We do not require States to count the costs of non-covered services towards the cumulative cost-sharing maximum. However, we encourage States to consider the additional costs of uncovered services particularly for families with special needs children, when imposing cost sharing. States may pursue this policy option by counting non-covered services toward the cumulative cost-sharing maximum or by implementing other State policies to limit the burden on such families.

4. Co-Payments, Coinsurance, Deductibles, or Similar Cost-Sharing Charges: State Plan Requirements (§ 457.515)

Section 2103(e)(1)(A) of the Act requires that the State plan include a description of the amount of premiums, deductibles, coinsurance and other cost sharing imposed. We proposed that the State plan describe the following elements regarding copayments, coinsurance, deductibles or similar charges: the service for which the charge may be imposed; the amount of the charge; the group or groups of enrollees to whom the charge applies; and the consequences for an enrollee who does not pay a charge. We proposed that the State plan describe the methodology used to ensure that total cost-sharing liability for an enrollee's family does not exceed the cumulative cost-sharing maximums. This description must explain how the State calculates total income for each family, and how the State will prevent charges over the cumulative cost-sharing maximums.

Finally, we proposed, in accordance with the prudent layperson standard in the Consumer Bill of Rights and Responsibilities, that States must provide assurances that enrollees will not be held liable for costs for emergency services above and beyond the copayment amount that is specified in the State plan. Specifically, we proposed that the State plan must include an assurance that enrollees will not be held liable for additional costs, beyond the copayment amounts specified in the State plan, that are associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network. In addition, we require that the State will not charge different copayment amounts for emergency services, based upon the location (in network or out of network) of the facility at which those services were provided. We indicated that we welcomed public comments on our proposed policy. In this final rule, we have added a provision to § 457.515(d) that States must describe in the State plan the disenrollment protections adopted by the State pursuant to § 457.570.

Comment: One commenter suggested that §§ 457.510(d) and 457.515(d), which require that the State plan describe the consequences for an enrollee who does not pay a charge, be revised to also require State plans to describe the consequences for a provider who does not receive a payment from an enrollee. The commenter indicated that providers should have information on the State's policy regarding unpaid copayments. The commenter questioned if providers may deny services to, or pursue collection from, enrollees who refuse to pay cost sharing. The commenter also asked if States will increase payments to providers when enrollees do not pay.

Response: Unlike under the Medicaid program, we do not have the statutory authority to prevent providers under separate child health programs from denying services to enrollees who do not pay their cost-sharing charges. Nor do we have clear authority to preclude providers or the State from billing the enrollee for unpaid cost-sharing charges. State plans should, consistent with fairness and equity, ensure that the provider or State gives the enrollee a reasonable opportunity to pay cost sharing before pursuing collection. Providers should refer the enrollee back to the State if he or she is demonstrating a pattern of non-payment, so that the State can review the financial situation of the enrollee. For example, the State should inquire whether the enrollee's income has dropped to a Medicaid eligibility level, or to a level of SCHIP qualification that does not require cost sharing or requires it at a lower level. We also suggest that States maintain open communication with providers regarding any financial losses for the provider resulting from non-payment of cost sharing. However, we note that the State's policy in this area is a matter of State discretion under this regulation.

Comment: One commenter urged HCFA to add a provision making clear that an enrollee may not be denied emergency services based on the inability to make a copayment, regardless of whether the provider is inside or outside of the enrollee's managed care network. The commenter also recommended that we include in the preamble a discussion of the obligations of emergency services providers under the Emergency Medical Treatment and Active Labor Act (EMTALA).

Another commenter suggested that as a general rule for all SCHIP services, including emergency services, cost-sharing limits should apply only to services delivered through network participating providers. If there is to be an exception to this rule for emergency services, then cost-sharing limits should only apply to out-of-network emergency service providers that are not within a reasonable distance of network participating providers.

Response: While this is not an appropriate vehicle to discuss EMTALA responsibilities at length, when those responsibilities are triggered, a hospital cannot turn away a patient solely because of inability to pay. In addition, § 457.410 requires States to provide coverage of emergency services; § 457.495 requires States to ensure that SCHIP enrollees have access to covered services, including emergency services; and § 457.515 specifies that enrollees cannot be held liable for cost sharing for emergency services provided outside of the managed care network.

If an enrollee goes outside of a managed care network to receive non-emergency services that are not authorized by the health plan, then the enrollee may be responsible for the full cost of the services provided. However, because of the nature of emergency services and the importance of ensuring that enrollees receive such services without delay or impediment, such a situation is not reasonable. Thus, as we discuss further below, we have retained the regulation text at § 457.515(f) providing that enrollee financial responsibility for emergency services must be equal whether the enrollee obtains the services from a network provider or out-of-network.

Comment: Several commenters supported the proposed requirement that beneficiary cost sharing for emergency services can not vary based on whether the provider is participating in a managed care network or not. One commenter specifically asserted that the use of differential copayments would be contrary to the spirit of the ''prudent layperson'' standard for emergency services. Another commenter recommended retaining or lowering the proposed maximum limit for copayments on emergency services, rather than raising the limit to levels parallel to those permitted in the Medicare+Choice programs, in light of the inability of many low-income families to access this amount at the time of an emergency.

Response: In keeping with the prudent layperson standard of assuring immediate access to emergency services, we have retained the prohibition against differential copays based upon location (in-network or out-of-network) under § 457.515(f). These services are required to address an emergency and can be time sensitive, and higher copayment levels for out of network providers might result in an unacceptable delay to determine whether the provider participates in the enrollee's managed care network. Furthermore, differential copayment levels might affect the ability of enrollees to access the closest and most accessible provider.

We have neither raised nor lowered the proposed permissible copayment levels for emergency services, because we believe the overall cost-sharing limitations are sufficient to protect enrollee families. We have not adopted the Medicare+Choice policy that would have permitted a $5.00 copayment for emergency medical services. The cost sharing provisions at § 457.555 will apply to emergency medical services.

Comment: We received a comment on our statement in the preamble that we considered adopting the Medicare+Choice policy regarding emergency services obtained outside of the provider network. The commenter noted that limitations on emergency room cost sharing at Medicare+Choice levels, whether in network or out of network, could be administratively burdensome to group health plans and participating providers, and might dissuade such entities and practitioners from contracting with SCHIP.

Response: As noted above, we have not adopted the Medicare+Choice policy described in the preamble to the proposed rule. We do note, however, that premium assistance programs are subject to the same cost-sharing requirements and protections as other types of SCHIP programs. Such protections are required by statute and recognize the unique financial constraints of the SCHIP population. In situations where employer plans charge more than is permissible under these rules, the State will need to develop a mechanism to prevent enrollees from paying excess charges.

5. Cost Sharing for Well-Baby and Well-Child Care (§ 457.520)

Under section 2103(e)(2) of the Act, the State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby and well-child care services in either the managed care or the fee-for-service delivery setting. At proposed § 457.520, we set forth services that constitute well-baby and well-child care for purposes of this cost-sharing prohibition. We proposed to define these well-baby and well-child services consistent with the definition of well-baby and well-child care used by the *American Academy of Pediatrics* (AAP) and incorporated in the Federal Employees Health Benefits Program (FEHBP) Blue Cross and Blue Shield benchmark plan.

We also proposed to apply the prohibition on cost sharing to services that fit the definition of routine preventive dental services used by the *American Academy of Pediatric Dentistry* (AAPD) when a State opts to cover these services under its program.

We proposed at § 457.520 that the following services are considered well-baby and well-child care services for the purposes of the prohibition of cost sharing under section 2103(e)(2):

- All healthy newborn inpatient physician visits, including routine screening (whether provided on an inpatient or on an outpatient basis).
- Routine physical examinations.
- Laboratory tests relating to their visits.
- Immunizations, and related office visits as recommended in the AAP's ''Guidelines for Health Supervision III'' (June 1997), and described in ''*Bright Futures:* Guidelines for Health Supervision of Infants, Children, and Adolescents'' (Green M., (ed.). 1994).
- When covered under the State plan (at the State's option) routine preventive and diagnostic dental services (for example, oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described by the AAPD's current Reference Manual (Pediatric Dentistry, Special Issue, 1997–1998, vol 19:7, page 71–2).

Comment: One commenter noted that the language of this section is ambiguous in stating that the ''State plan may not impose copayments, deductibles, coinsurance or other cost sharing with respect to well-baby/well child care services as defined by the State.'' HCFA should clarify that no preventive service as defined by the Guidelines for Health Supervision III (including the appended Recommendations for Preventive Pediatric Health Care) and Bright Futures is subject to cost sharing, as was intended by the underlying statute.

Response: We agree with the commenter and have revised § 457.520(a) to be clearer that a State may not impose cost sharing on services that would ordinarily be considered well-baby and well-child care. As described in subpart D, Benefits, States may define well-baby and well-child services for coverage purposes. While this may provide States flexibility in determining the appropriate scope of

benefits, such flexibility is not appropriate with respect to cost sharing which might deter appropriate utilization of covered services. Thus, we are specifying in § 457.520(a) that cost sharing may not be imposed on any covered services that are also within the scope of AAP well-baby and well-child care recommendations.

Comment: One commenter noted that there are differences between the discussion of this provision in the preamble (64 FR 60913) and in the regulations text (64 FR 60955). The commenter believed the provision as set forth in the regulations text is more clear.

Response: In this final rule, we are adopting the provisions regarding well-baby and well-child care as set forth in the regulations text at § 457.520, except that we have amended these provisions to clarify the scope of services to which the prohibition on cost sharing applies.

Comment: A number of commenters expressed concern that adolescent health care services are not specifically listed as well-baby and well-child care services exempt from cost sharing. Although the preamble notes that well-child care includes health care for adolescents, the commenters urged HCFA to make specific mention of this fact in the regulation. One commenter recommended that HCFA define adolescent health care services using the schedules from the American Medical Association's ''Guidelines for Adolescent Preventive Services,'' and the American College of Obstetricians and Gynecologists, ''Primary and Preventive Health Care for Female Adolescents'' as well as those of the American Academy of Pediatrics. Another commenter noted that there is no reason why a physical exam for a toddler should be exempt from cost-sharing requirements while an exam and related services for an adolescent are not.

Response: It is not necessary to add the term adolescent to the regulation because the term ''child'' as defined by the statute and regulation refers to enrollees under the age of 19 the cost-sharing rules set forth in this regulation apply to all children under age 19. Therefore, States cannot impose cost sharing on any well-child care services provided to an adolescent under the age of 19. In addition, the standard recommended by the AAP for routine physical exams specifically includes treatment of adolescents.

Comment: One commenter disagreed with the use of a specific immunization schedule because it may be difficult for States using employer-sponsored insurance to implement this requirement. The commenter recommended that we revise the regulation to state ''Immunizations and related office visits *as medically necessary.*''

Response: We are not accepting the commenter's suggestion because immunizations recommended by the Advisory Commission on Immunization Practices (ACIP) are generally accepted as being medically necessary. The State is responsible for assuring that an enrollee does not pay cost sharing for any immunizations recommended by ACIP.

Comment: One commenter recommended that the immunization schedule include updates.

Response: As proposed, § 457.520(b)(4) prohibits cost sharing for immunizations and related office visits as recommended by ACIP. We are retaining this language in the final regulation at § 457.520(b)(4) which also indicates that updates to these guidelines must be reflected in States cost-sharing policies.

Comment: One commenter urged that HCFA remove the term ''routine physical examinations'' from the list of well-baby and well-child care services. The inclusion of this term is confusing in this commenter's view because almost every office visit for children entails a ''physical examination'' as part of the evaluation and management component of the office visit. As an alternative, the commenter recommended using the language for well-baby and well-child care services as listed in § 457.10. Other commenters recommended that routine exams be specifically tied to professionally established periodicity schedules.

Response: We agree that our intent may have been unclear. We have revised § 457.520(b)(2) to provide that the well-baby and well-child routine physical exams, as recommended by the AAP's ''Guidelines for Health Supervision III'', and described in ''Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents'', (which would include updates to either set of guidelines) may not be subject to cost sharing.

Comment: Several commenters stated that lab tests should not be exempt from cost sharing, especially given that lab tests are expensive and not always preventive. Since lab services are provided by a separate entity, outside of the office of the physician providing the well-baby and well-child care service, States should be given flexibility in determining whether to exempt lab services from cost sharing, particularly in managed care settings. One commenter requested that HCFA clarify the intention of the provisions excluding lab services from cost sharing. The commenter questioned if the exemption is limited to laboratory tests that are associated with the well-baby and well-child visit.

Response: We have revised the regulation text at § 457.520(b)(3) to indicate that States are required to exempt from cost sharing only those lab tests associated with the well-baby/well-child routine physical exams described in § 457.520(b)(2). We believe the exemption from cost sharing for these lab tests is consistent with the statutory intent that there is no cost sharing imposed on enrollees for well-baby and well-child care services. All other lab tests that are not routine and not part of a well-baby or well-child visit may be subject to cost-sharing charges consistent with the other cost-sharing provisions of this subpart.

Comment: Several commenters indicated their view that States should have the flexibility to determine how best to improve access to dental services. In their view, the prohibition of cost-sharing for dental services may discourage States from offering dental services under SCHIP because it is an optional benefit. One commenter recommended prohibiting States from imposing copayments, deductibles, coinsurance or other cost sharing for all covered dental services. This commenter indicated that the Medicaid program has clearly demonstrated that imposing costly, difficult, and risk shifting management procedures on providers severely limits participation in such programs and therefore severely restricts access to essential oral health care for this high risk, high need population. The commenter stated that, for example, if a child arrives in a dental office without the appropriate cost-sharing funds, the practitioner must either defer the needed service, enter into costly billing procedures, or waive the money due and such waivers previously have, on some occasions, been interpreted as insurance fraud. The commenter indicated that our policy may discourage practitioners from participating in the SCHIP program and result in problems of access to care for the children with the greatest need.

Response: The majority of separate child health programs offer dental benefits and do not impose cost sharing on preventive dental services. If States were to impose cost sharing on preventive benefits, due to their limited incomes, enrollees would only access services when needed and when services are most expensive. Almost all States have elected to provide at least some dental coverage in their State

plans without cost sharing for preventive services. The cost-sharing exemption policy has not caused States to discontinue coverage of dental services thus far. In addition, we note that the cost-sharing exemption on well-baby and well-child care services is based upon section 2103(e)(2)of the Act, which provides that the State plan may not impose cost sharing on benefits for these preventive services. We have interpreted this statutory provision to support the cost-sharing exemption for routine preventive and diagnostic dental services.

6. Public Schedule (§ 457.525)

Section 2103(e)(1)(A) of the Act requires that the State provide a public schedule of all cost-sharing charges. We proposed that the public schedule contain at least the current SCHIP cost-sharing charges, the beneficiary groups upon whom cost sharing will be imposed (for example, cost sharing imposed only on children in families with income above 150 percent of the FPL), the cumulative cost-sharing maximums, and the consequences for an enrollee who fails to pay a cost-sharing charge. We also proposed that the State must make the public schedule available to enrollees at the time of enrollment and when the State revises the cost-sharing charges and/or cumulative cost-sharing maximum, applicants at the time of application, SCHIP participating providers and the general public. To ensure that providers impose appropriate cost-sharing charges at the time services are rendered, we proposed that the public schedule must be made available to all SCHIP participating providers. In this final rule, we have added § 457.525(a)(4) which indicates that the State must include in the public schedule, the mechanisms for making payments for required charges. We also added to § 457.525(a)(5) that the public schedule describe the disenrollment protections pursuant to § 457.570.

Comment: Several commenters recommended that States have the option to provide information in the public schedule that defines cumulative cost sharing as a percentage of income. The commenters requested that we clarify that States can defer responsibility for distributing the public schedule to all SCHIP providers to the managed care entities as part of their contractual obligations.

Response: States may define the cumulative cost-sharing maximum as a percentage of income in the public schedule and request that managed care entities distribute the public schedule to all SCHIP providers (although the State retains the responsibility that the entities involved make the schedule available to providers). However, we have modified the regulation at § 457.110(b)(2) to indicate that States must calculate the precise amount of the cumulative cost-sharing maximum (the dollar amount instead of a percentage of income) that applies to the individual enrollee's family at the time of enrollment (as well as at the time of re-enrollment) to maximize the usefulness of information provided to the family and to ensure uniform calculation of the amount, maximize the usefulness of the information, and make tracking easier.

Comment: One commenter urged HCFA to include language in the preamble that ''applicants'' and ''enrollees'' include adolescents (independent from other children in their family) and that information should be directed to them about any schedule of costs. The commenters noted that adolescents often seek care on their own, not only for services that they need on a confidential basis, but for other services as well. Unless they are aware of the charges they may encounter, and the services that do not require a copayment, they may be deterred from seeking care, in this commenter's view.

Response: Section 457.525(b) specifically requires States to provide a public schedule, which includes a description of the plan's current cost-sharing charges, to SCHIP enrollees at the time of application, enrollment, and when cost-sharing charges are revised. We have added a provision at § 457.525(b)(1) requiring that States provide SCHIP enrollees the public schedule at reenrollment after a redetermination of eligibility as well. This section also requires that cost-sharing charges be disclosed to SCHIP applicants at the time of application. SCHIP enrollees, by definition, are children under age 19. In most cases, this information will be given to family members due to the age of the child. However, we encourage States to provide information about cost sharing directly to adolescent applicants and enrolles when appropriate. We also encourage States to consider the range of applicants, enrollees and family members who might benefit from the provision of this information, including adolescents, and we encourage States to describe the plan's current cost-sharing charges in language that is easily understood and tailored to the needs of target populations, consistent with section 457.110.

Comment: One commenter suggested that the requirement to provide the public schedule to applicants may be overwhelming to both the program and the applicants. Enrollees are most interested in the information relating to the family's individual obligations.

Response: Section 2103(e)(1)(A) of the Act provides sufficient authority to require States to make a public schedule available, and to provide all interested parties with notice of cost-sharing obligation for the program. In addition, applicants should be given a chance to review the cost sharing structure prior to enrollment, so that the applicant will understand the potential costs of SCHIP and can make a reasoned choice as a health care consumer. This policy also aids in future tracking of the family's cost-sharing obligation.

Comment: One commenter recommended that HCFA require that the public schedule contain information about an enrollee's rights with respect to cost sharing, including the right to receive notice and make past due payments, as well as other protections established by the State in compliance with § 457.570.

Response: Section 457.525(a)(5) of this final rule requires that the public schedule include a description of the consequences for an enrollee who does not pay a cost-sharing charge. We are also revising this section to require States to discuss, as part of this description, the disenrollment protections it has established pursuant to § 457.570. Section 457.570 requires States to provide enrollees with an opportunity to pay past due cost sharing, as well as an opportunity to request a reassessment of their income, prior to disenrollment.

Comment: One commenter recommended that we require States to include detailed information about the cost-sharing schedule at each annual renewal and in the SCHIP application packet/pamphlet. Applications should also include information to notify participants of services that are subject to cost sharing.

Response: We have revised § 457.525(b)(1) to require that States also provide the public schedule at the time of a re-enrollment after a redetermination of eligibility. In addition, we note that § 457.525(a)(1) requires that the public schedule of cost-sharing requirements include information on current cost-sharing charges and the cumulative cost-sharing maximums. This information should specify the services or general category of services for which cost sharing is imposed and services that are exempt from cost sharing.

7. General Cost-Sharing Protection for Lower Income Children (§ 457.530)

At § 457.530, we proposed to implement section 2103(e)(1)(B) of the Act, which specifies that the State plan may only vary premiums, deductibles, coinsurance, and other cost-sharing charges based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income. We noted that this statutory provision and the implementing regulations apply to all cost sharing imposed on children regardless of family income.

Comment: One commenter requested that when considering the requirement that States not vary cost sharing based on the family income of the targeted low-income children in a manner that favors children from families with higher income over children from families with lower income, HCFA should consider the issue of disposable income. The commenter recommended that we should consider only the income the family receives above 100 percent of the FPL (disposable income). When applying a flat percentage assessment, the assessment will consume more of the lower-income family's disposable income than the disposable income of a higher-income family. The commenter cited the following example: A straight 3 percent assessment would consume 9 percent of the disposable income for a family at 150 percent of poverty but only 6.5 percent of the income for a family at 185 percent of poverty.

Response: We recognize that health care costs may consume a larger proportion of a lower income family's disposable income. Accordingly, at § 457.560(d), we provide for a lower cumulative cost-sharing maximum (2.5 percent) for cost sharing imposed on children in families at or below 150 percent of the FPL in part because of the higher proportionate consumption of disposable income at lower poverty levels. Also, in accordance with § 457.540(b), and section 2103(a)(1)(B) of the Act, copayments, coinsurance, deductibles and similar charges imposed on children whose family income is at or below 100 percent of the FPL may not be more than what is permitted under the Medicaid rules at § 447.52 of this part and the charges may not be greater for children in lower income families than for children in higher income families.

8. Cost-Sharing Protection to Ensure Enrollment of American Indians/Alaska Natives (§ 457.535)

Section 2102(b)(3)(D) of the Act requires the State plan to include a description of the procedures used to ensure the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act). To ensure the provision of health care to children from AI/AN families, we proposed that States must exclude AI/AN children from the imposition of premiums, deductibles, coinsurance, copayments or any other cost-sharing charges. For the purposes of this section, we proposed to use the definition of Indians referred to in section 2102(b)(3)(D) of the Act, which defines Alaska Natives and American Indians as Indians defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). We also specified in the regulation that the State must only grant this exception to AI/AN members of Federally recognized tribes (as determined by the Bureau of Indian Affairs).

Comment: Several commenters requested that HCFA reconsider the AI/AN exemption. Many commenters noted that it is administratively burdensome (especially in States with small AI/AN populations) and expensive in light of the fact that a number of States have already negotiated contracts with health care entities that assume cost sharing for this population and application of the 10 percent limit on administrative expenditures. Many commenters recommended that we focus on technical assistance instead to assure that States are consulting with tribes. Some commenters were concerned that having no cost sharing for this group, but having it for other children in the program would single out AI/AN children in health care provider offices and facilities. Also, commenters believed our policy contradicts the statutory intent to prevent discrimination against children with lower family incomes. In their view, the elimination of cost sharing in these situations creates a different standard for a specific population group and may imply to both providers and families SCHIP enrollees that AI/AN children's parents cannot be relied upon to pay anything toward the costs of their health care. One commenter observed that if HCFA's reason for exemption is because AI/AN children are typically unable to pay cost sharing, then the exemption should apply to special needs children as well.

Response: Section 2102(b)(3)(D) of the Act requires that a State ensure the provision of child health assistance to targeted low-income children in the State who are Indians. In accordance with this statutory provision and to enhance access to child health assistance, we have specified that States may not impose cost sharing on this population. This exemption is consistent with section 2103(e)(1)(B) of the Act because this statutory provision prohibits States from imposing cost sharing based on the family income of targeted low-income children in a manner that favors children from families with higher income over children from families with lower income. The exemption from cost sharing for AI/AN children is not a variation of the cost sharing based on the family's income and is not a violation of section 2103(e)(1)(B). The cost-sharing exemption for AI/AN children is based upon the statutory requirement at section 2102(b)(3)(D), which requires particular attention to this population.

This cost-sharing exemption also reflects the unique Federal trust with and responsibility toward AI/ANs. The statute specifically singles out children who are AI/ANs and requires that States ensure that such children have access to care under SCHIP. The statute confirms that AI/AN children are a particularly vulnerable population, and that a requirement to pay cost sharing will act as a barrier to access to care for this population. Therefore, in order to operate a SCHIP program in compliance with section 2103(b)(3)(D), the only way to ensure access to AI/AN children is to exempt them from the cost-sharing requirements. In addition, absent this exemption for AI/AN children, these children may pursue services from the Indian Health Service (IHS) (where cost sharing is not required) without pursuing coverage under SCHIP or Medicaid. We disagree with the commenter's assertion that a similar exemption should be granted for children with special needs, there is no parallel statutory provision that requires States ensure access to this population. While the unique medical needs of this population are not insignificant, the AI/AN exemption is based on the Federal tribal relationship and responsibility for protection of this specific group. However, we do not believe there is sufficient rationale or authority for including special needs children under this exemption.

We further recognize that it may be administratively burdensome for some States to exempt this population if States are required to verify the status of

the enrollee as Indians. However, States may rely on the beneficiary to self-identify their membership in a Federally-recognized tribe and self-identification would substantially reduce the administrative burden and associated costs to the State. Also, this exemption will not single out AI/AN children at providers' offices and facilities if the State requires the enrollee to self-identify at the time of enrollment and the State provides inconspicuous identification for these children so that providers know not to charge them cost sharing at the time the enrollee receives services.

Comment: One commenter asked HCFA to clarify that cost-sharing charges are not imposed by Tribal clinics or community health centers.

Response: Under § 457.535, the AI/AN population is exempt from cost sharing. IHS facilities and tribal facilities operating with funding under P.L. 93–638 (''tribal 638 facilities'') do not charge cost sharing to the AI/AN population.

Comment: Several commenters recommended that the States' costs incurred due to the AI/AN exemption should be reimbursed with 100 percent Federal funds.

Response: A State will be able to claim match for increased costs resulting from the AI/AN exemption at the State's enhanced matching rate. However, we do not have authority under title XXI to provide 100 percent FMAP for these costs and would therefore need a legislative change to do so.

Comment: Several commenters recommended that AI/AN enrollees be permitted to self-certify their AI/AN status if HCFA does not concur with the commenter's request to remove the AI/AN cost-sharing exemption.

Response: We agree and take note that we have revised the policy set forth in the preamble to the proposed rule. States may allow self-identification for the purposes of the AI/AN cost-sharing exemption. Self-identification is consistent with our policies that encourage States to simplify the application and enrollment processes.

Comment: One commenter suggested that we apply the AI/AN cost-sharing exemption to all Indians based on the definition referred to in section 2102(b)(3)(D). The commenter requested that we remove the provision in the proposed regulation at § 457.535 that would narrow this definition to ''AI/AN members of *a Federally recognized tribe*.'' The commenter stated that this definition of AI/AN children is more restrictive than that in the Indian Health Care Improvement Act, has no basis in title XXI and it is also inconsistent with the definition of Indian set forth in the consultation provisions at § 457.125(a), which expressly request that States consult with ''Federal recognized tribes and other Indian tribes and organizations in the State * * *'' The commenter indicated the view that there is little point in consulting with non-Federally recognized tribes about enrollment in SCHIP if the children of those tribes are not excluded from the premiums and cost sharing.

Response: Because the Federal/tribal relationship is focused only on AI/ANs who are members of Federally recognized tribes, this final rule only requires States to exempt from cost sharing AI/ANs who are members of Federally recognized tribes. With regard to the consultation requirements at proposed § 457.125(a), we note that, although the cost-sharing exemption is required only for AI/ANs who are members of a Federally recognized tribe, individuals from other tribes may be eligible for child health assistance under SCHIP. There are numerous issues other than cost sharing that are involved in designing and operating a program, and we believe that States should be open to consultation with all interested parties, including non-federally recognized tribes. As such, we have removed the consultation requirement from § 457.125 and encourage the participation of these groups in the public involvement process established by the State in accordance with the new § 457.120(c). Finally, we have modified the definition of American Indian/Alaska Native at § 457.10 to be consistent with the Indian Health Care Improvement Act, yet also comport more closely with the definition used in the Indian Self Determination Act (ISDEAA).

Comment: One commenter suggested that HCFA allow time for States to comply with this new requirement and not delay approval of State plans or plan amendments for the time it will take to change State law to implement this change.

Response: In a letter dated October 6, 1999, HCFA informed SCHIP State health officials that we interpret the SCHIP statute to preclude cost sharing on AI/AN children. Since October 1999, we have required States submitting State plan amendments to alter cost sharing to comply with the exemption in order to gain approval for these amendments. States that have not submitted such amendments have been given ample notice of this policy. We will expect all States to comply with the requirements of § 457.565(b), which implements the exemption of AI/AN targeted low-income children from cost sharing and comply immediately with this requirement upon the effective date of this regulation.

Comment: One commenter suggested that States with small AI/AN Indian populations be waived from the cost sharing exemption so they can continue their programs as implemented.

Response: We realize there is some concern about the administrative difficulties related to exempting AI/AN children from cost sharing in States with small AI/AN populations. However, as noted above, we will permit AI/AN applicants to self-identify at the time of enrollment for the purposes of the cost-sharing exemption. This policy minimizes the administrative burden on States.

Comment: Two commenters asked HCFA to clarify that, in States with SCHIP or Medicaid expansions involving AI/AN adults or entire families, the cost-sharing exemption be applied to AI/AN adults as well.

Response: In States with separate child health programs or Medicaid expansions that provide coverage to AI/AN adults or entire AI/AN families, the cost-sharing exemption only applies to children. If a State has imposed a premium on the family, the State must reduce the premium proportionately so that it applies to adults only. They also must not deny children access to coverage if the adults in the family cannot make premium payments. We are not restricting cost sharing for AI/AN adults because section 2102(b)(3)(D) directly refers to children only.

9. Cost-Sharing Charges for Children in Families at or Below 150 Percent of the Federal Poverty Line (FPL) (§ 457.540)

Section 2103(e)(3) of the Act sets forth the limitations on premiums and other cost-sharing charges for children in families with incomes at or below 150 percent of the FPL. Pursuant to section 2103(e)(3)(A)(I) of the Act, we proposed that in the case of a targeted low-income child whose family income is at or below 150 percent of the FPL, the State plan may not impose any enrollment fee, premium, or similar charge that exceeds the charges permitted under the Medicaid regulations at § 447.52, which implement section 1916(b)(1) the Act. Section 447.52 specifies the maximum monthly charges in the form of enrollment fees, premiums, and similar charges, for Medicaid eligible families.

Section 2103(e)(3)(A)(ii) provides that copayments, coinsurance or similar charges imposed on children in families with income at or below 150 percent of the FPL must be nominal, as determined consistent with regulations referred to in section 1916(a)(3) of the Act, with

such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. The Medicaid regulations that set forth these nominal amounts are found at § 447.54. For children whose family income is at or below 100 percent of the FPL, we proposed that any copayments, coinsurance, deductibles or similar charges be equal to or less than the amounts permitted under the Medicaid regulations at § 447.54. For children whose family income is at 101 percent to 150 percent of the FPL, we proposed adjusted nominal amounts for copayments, coinsurance, and deductibles to reflect the SCHIP enrollees ability to pay somewhat higher cost sharing. We proposed that the frequency of cost sharing meet the requirements set forth in proposed § 457.550.

We also proposed that the cost sharing imposed on children in families with incomes at or below 150 percent of the FPL be limited to a cumulative maximum consistent with proposed § 457.560. Specifically, we proposed that total cost sharing imposed on children in this population be limited to 2.5 percent of a family's income for a year (or 12 month eligibility period).

Comment: One commenter questioned if the cost-sharing limits at §§ 457.540, 457.545, 457.550, 457.555 and 457.560 apply to out-of-network cost-sharing charges. The commenter recommended that the limits only apply to services delivered through the network participating providers. If not, the commenter argued that States cannot effectively use managed care to control costs and will be unable to develop effective partnerships with employer-sponsored health insurance programs to provide SCHIP services.

Response: If an enrollee receives services outside of the network that were not approved or authorized by the managed care entity (MCE) to be received outside of the network, then the services are considered non-covered services and the enrollee may be responsible for related cost-sharing charges imposed (other than in the case of emergency services provided under § 457.555(d)) irrespective of the limits established under the above referenced sections. If, however, the services are authorized by the MCE and provided by an out-of-network provider, the cost-sharing limits of this subpart apply. A State must ensure enrollees access to services covered under the State plan, but a State has discretion over whether to use a fee-for-service or a managed care arrangement.

Comment: A couple of commenters observed that the premium limits as set forth in the Medicaid regulations at § 447.52 are unreasonably low, since these cost-sharing provisions and limits have not been updated since the 1970s. These commenters proposed that we use a percentage (of payment) to set these amounts instead of a flat dollar amount.

Response: Section 2103(e)(3)(A)(I) provides that States may not impose enrollment fees, premiums or similar charges that exceed the maximum monthly charges permitted, consistent with the standards established to carry out section 1916(b)(1) of the Act. Permitting States to charge higher premiums on families with incomes at this level of poverty would be inconsistent with the statute.

Comment: One commenter suggested that the rule and preamble explicitly address the cost sharing treatment of children in families below the Federal Poverty Level. They noted that, in States that have retained the resource test for children in Medicaid, significant numbers of children below poverty will be enrolled in separate child health programs due to excess assets. This commenter recommended that § 457.540 be revised to reflect the fact that some adolescents under 100 percent of the FPL may be receiving SCHIP services until they are fully phased into regular Medicaid and that protections must apply to these children as well.

Response: Section 457.540(b) of the proposed regulation addresses the need for lower cost-sharing limits for cost sharing imposed on all children below 100 percent of the FPL. This section limits cost sharing to the uninflated Medicaid cost-sharing limits permitted under § 447.54 of this chapter. Section 2103(e)(3)(A)(I) limits premiums, enrollment fees, or similar charges to the maximums permitted in accordance with section 1916(b)(1) of the Act. In addition, because the definition of ''child'' includes adolescents under the age of 19, there is no need to revise this section. We have retained this proposed provision in the final regulation. However, it should be noted that we have added paragraphs (d) and (e) to § 457.540. These requirements were originally part of § 457.550, which has been removed to improve the format of the regulation.

Comment: One commenter disagreed with the separate grouping, relative to cost sharing, for SCHIP enrollees under 100 percent of the FPL and the application of the Medicaid cost-sharing limits to this population. The commenter noted that the proposal is beyond the statute (the statute only refers to two tiers—above 150 percent of the FPL and at or below 150 percent of the FPL) and that the monetary difference between the SCHIP schedule applicable to 101 percent to 150 percent of the FPL and the Medicaid cost-sharing schedule is minimal. The commenter noted that the cost to States to create a program for this new income level is very significant. The commenter argued that the Medicaid cost-sharing requirements proposed for SCHIP enrollees under 100 percent FPL were developed two decades ago and have no connection to current health care costs or program changes. According to this commenter, creating this new tier of eligible SCHIP enrollees does not seem to comport with the flexibility provided States in the Congressional debate on SCHIP, or written in title XXI.

Response: Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose ''a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with the regulations referred to in section 1916(a)(3) of the Act), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable.'' The Secretary has the discretion to determine the increases to the Medicaid cost-sharing limitations that are reasonable and under this authority the Secretary has determined that it is not reasonable for States to impose cost sharing above the Medicaid limitations contained in § 447.54 for children with family incomes that are below the Federal poverty line. As noted in the comment above, children at this income level who are eligible for separate child health programs typically reside in States that have retained the resource test for children in Medicaid, and may be well below 100 percent of the FPL. In this case, even small increments in cost sharing may impact the ability to access services.

10. Cost Sharing for Children in Families Above 150 Percent of the FPL (§ 457.545)

Section 2103(e)(3)(B) mandates that the total annual aggregate cost sharing with respect to all targeted low-income children in a family with income above 150 percent of the FPL not exceed 5 percent of the family's income for the year involved. The proposed regulation provided that the plan may not impose total premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges in excess of 5 percent of a family's income for a year (or 12 month eligibility period). We have deleted this section because it repeats the requirements already stated in § 457.560(c). Please see the comments and responses at § 457.560(c) for further discussion.

11. Restriction on the Frequency of Cost-Sharing Charges on Targeted Low-Income Children in Families at or Below 150 Percent of the FPL (§ 457.550)

Section 2103(e)(3)(A)(ii) of the Act specifies that the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, ''with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable''. We proposed to adopt the Medicaid rule at § 447.53(c) that does not permit the plan to impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service. We also proposed that a State may not impose more than one cost-sharing charge for multiple services provided during a single office visit.

We also proposed to adopt the Medicaid rules at § 447.55 regarding standard copayments. Specifically, we proposed to provide that States can establish a standard copayment amount for low-income children from families with incomes from 101–150 percent FPL for any service. We proposed to expand upon the Medicaid rules and allow States to provide a standard copayment amount for any visit. Similar to the provisions at § 447.55 that allow a standard copayment to be based upon the average or typical payment of the service, our proposed provision would allow a State to impose a standard copayment per visit for non-institutional services based upon the average cost of a visit up to the copayment limits specified at proposed § 457.555(a), on these families.

Comment: A few commenters asked if States can still charge an enrollment fee. HCFA should clarify that States can charge both an enrollment fee for SCHIP and copayments for services, provided aggregate and individual dollar limits on cost sharing are observed.

Response: States can charge an enrollment fee for families at or below 150 percent FPL as long as the enrollment fee does not exceed the maximums specified in § 457.540(a) for children in families at or below 150 percent of the FPL and does not exceed the cumulative cost-sharing maximum in accordance with § 457.560(d) (2.5 percent of a family's income for a year or length of the child's eligibility period). For enrollment fees imposed on children in families with income above 150 percent of the FPL, enrollment fees and other cost sharing are limited to the cumulative cost-sharing maximum specified in § 457.560(c) (5 percent of the enrollee's family income for a year or the length of the child's period of eligibility). The restriction on imposition of one type of cost sharing in this section applies only to copayments, deductibles, and coinsurance or similar charges.

Comment: One commenter strongly supported the provision of the proposed rule that prohibits imposition of more than one copayment for multiple services provided during a single office visit. The commenter noted that this is a key issue for adolescents and that adolescents seek a variety of health care services on their own and seek to do so on a confidential basis (for example, diagnosis and treatment for a sexually transmitted disease). The commenter recommended that the preamble (or regulation) clarify whether there can be only one copayment required for a single office visit (for example, a $5.00 copayment for the visit) and whether the copayment must cover any associated lab tests, diagnostic procedures, and prescription drugs, or whether any additional copayments can be required. The commenter urged that HCFA make clear that only one copayment per visit may be required for all services associated with the single visit.

One commenter opposed the prohibition on imposing more than one cost-sharing charge for multiple services provided during a single office visit. In the commenter's view, cost sharing should relate to the provision of services rather than a visit. The commenter noted that CPT IV codes for physicians do not bundle multiple physicians or multiple services into a single visit. In this commenter's view, the proposed rule is also more restrictive than the current Medicaid provisions, which tie cost sharing to services, not to visits. The commenter argued that this added restraint on cost sharing is unnecessary because SCHIP enrollees are already protected from excessive charges by the overall cost-sharing caps and the limits on copayments.

Response: Section 457.550(b) (now § 457.540(e)) specifies that States cannot impose more than one copayment for multiple services furnished during one office visit. Thus, the copayment must cover any associated lab tests and diagnostic procedures. Only one copayment per visit may be required for all services delivered during the single visit. Lab tests performed at another site or prescription drugs obtained at a pharmacy may be subject to additional copayments. While the commenter notes that this is more restrictive than Medicaid, under Medicaid a provider cannot deny services to an enrollee if he or she cannot pay the associated copayment. SCHIP providers can deny services to enrollees under these circumstances. The per visit cost-sharing limit is intended to prevent access problems for SCHIP enrollees.

Comment: Several commenters requested that § 457.550(b) not apply to dental services or vision services because they are benefits that are defined by each individual service. In these commenters' view, limiting the frequency of cost sharing jeopardizes the State's ability to contract with many participating dental providers and limits the provision of needed dental services for SCHIP enrollees.

Response: The majority of State child health programs offer coverage for dental services and we believe this provision will not adversely affect State coverage of these services. In addition, provider participation is more likely to be influenced by States' payment rates than by cost sharing from enrollees. Once again, we believe it is important that the cost sharing on enrollees at or below 150 percent of the FPL be nominal in order to encourage enrollees to access vision and dental services before more expensive treatment is required.

Comment: One commenter indicated that § 447.550(b) should state that ''any copayment that the State imposes under a fee for service system may not exceed $5.00 per visit, regardless of the number of services furnished during one visit.'' Because the commenter assumes that the provider will seek the highest allowable copayment, for clarity, the rule should simply state that $5.00 is the maximum allowable per copayment visit. Section 457.550(b) is redesignated as § 457.540(e).

Response: We have modified the regulation to clarify that the provider can only collect up to the maximum amount allowed by the State based on the total cost of services delivered during the office visit. The provider cannot charge copayments in excess of what the State permits under the State plan.

Comment: One commenter pointed out an error in paragraph (c) of § 457.550, which refers to the maximum copayment amounts specified in paragraphs (b) and (c) of this section. The reference should be to § 457.555 (b) and (c).

Response: We agree with the commenter and have made these corrections to the final regulation text (§ 457.550(c) has been redesignated as § 457.555(e)). In addition, we have revised the reference to include subsection (a) as well.

12. Maximum allowable cost-sharing charges on targeted low-income children between 101 and 150 percent of the FPL (§ 457.555).

Section 2103(e)(3)(A)(ii) of the Act specifies that for children in families with incomes below 150 percent of the FPL, the State plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with regulations referred to in section 1916(a)(3) of the Act, ''with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable''. We proposed provisions regarding maximum allowable cost-sharing charges on targeted low-income children at 101 to 150 percent of the FPL that mirror the provisions of §§ 447.53 and 447.54 but are adjusted to permit higher amounts.

Specifically, for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent we proposed the following service payment and copayment maximum amounts for charges imposed under a fee-for-service system:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
$15.00 or less	$1.00
$15.01 to $40	2.00
$40.01 to $80	3.00
$80.01 or more	5.00

We proposed to set a maximum per visit copayment amount of $5.00 for enrollees enrolled in managed care organizations. In addition, we proposed to set a maximum on deductibles of $3.00 per month per family for each period of SCHIP eligibility. We noted that, if a State imposes a deductible for a time period other than a month, the maximum deductible for that time period is the product of the number of months in the time period by $3.00. For example, the maximum deductible that a State may impose on a family for a three-month period is $9.00.

We also proposed, for the purpose of maximums on copayments and coinsurance, that the maximum copayment or coinsurance rate relates to the payment made to the provider, regardless of whether the payment source is the State or an entity under contract with the State.

With regard to institutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL, we proposed to use the standards set forth in the Medicaid regulations at § 447.54(c). Accordingly, we proposed to require that for targeted low-income children whose family income is at or below 150 percent of the FPL, the State plan must provide that the maximum deductible, coinsurance or copayment charge for each institutional admission does not exceed 50 percent of the payment made for the first day of care in the institution.

We proposed to allow States to impose a charge for non-emergency use of the emergency room up to twice the nominal charge for noninstitutional services provided to targeted low-income children whose family income is from 101 to 150 percent of the FPL. In § 457.555(d), we further proposed that States must assure that enrollees will not be held liable for additional costs, beyond the specified copayment amount, associated with emergency services provided at a facility that is not a participating provider in the enrollee's managed care network.

We realized that the regulation text as proposed regarding the limit on cost sharing related to emergency services was not clear. Therefore, we have added to § 457.555(a) that the cost-sharing maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph (c) that any cost sharing the State imposes for services provided by an institution to treat an emergency medical condition may not exceed $5.00. We also removed proposed paragraph (d), because this requirement is already included in § 457.515(f)

Comment: One commenter suggested that copayments and deductibles for families with incomes over 150 percent of the FPL be subject to the same limits that apply for families with incomes 101 to 150 percent of the FPL, noted in § 457.555 (a) and (b).

Response: The limitations proposed in § 457.555 (a) and (b) implement section 2103(e)(3)(A)(ii)of the Act. This section of the Act only applies to cost sharing imposed on targeted low-income children in families at or below 150 percent of the FPL. With respect to targeted low-income children in families above 150 percent of the FPL, the statute explicitly sets forth different cost-sharing provisions at 2103(e)(3)(B) and permits States to impose cost sharing that is only subject to the 5 percent cumulative cost-sharing maximum. Therefore, we do not have the statutory authority to apply these limits to cost sharing on children in families with incomes above 150 percent of the FPL.

Comment: One commenter encouraged HCFA to make the maximum allowable cost-sharing charges consistent with Medicaid. The commenter noted that a family with an income at or below 150 percent of the FPL enrolled in SCHIP has the same disposable income as a family with an income at or below 150 percent of the FPL in Medicaid, and therefore should not be expected to absorb a higher cost-sharing limit. Also, in this commenter's view, because the family may move from one program to another, there should be consistency in cost sharing.

Another commenter stated that the cost-sharing limits in this section should have been based on the Medicaid maximums increased by the actual inflation experienced since the promulgation of the original Medicaid regulations.

Response: Section 2103(e)(3)(ii) of the Act limits the copayments, deductibles, or similar charges imposed under SCHIP, for families with incomes at or below 150 percent of the FPL, to Medicaid cost-sharing amounts ''with such appropriate adjustments for inflation or other reasons as the Secretary determines to be reasonable.'' The cost-sharing amounts under Medicaid (found at 42 CFR 447.52) were originally established in regulation in 1976 and have never been adjusted for inflation. Therefore, using the discretion permitted under the statute, we inflated the schedule for SCHIP for cost sharing imposed on enrollees whose income is from 101 to 150 percent of the FPL. In doing so, we looked at both the general inflation rate and the level of need in the population at issue in reference to Medicaid recipients. Because children in families with incomes below the poverty line are more closely tied to the traditional Medicaid population, we have not inflated the Medicaid cost sharing limits found at § 447.52 for SCHIP enrollees with incomes at or below 100 percent of the FPL. We also note that under Medicaid, States cannot impose copayments, deductibles, and coinsurance on children under the age of 18. Therefore, children under the age of 18 who become eligible for the Medicaid program should not be subject to any copayments, deductibles or similar charges in accordance with § 447.53 of the Medicaid regulations. The SCHIP statute, however, clearly contemplates and permits the application of cost-sharing to SCHIP enrollees.

Comment: One commenter supported the higher cost sharing for non-emergency use of the emergency room. The commenter believes in promoting the concept of the medical home and

encouraging families to receive their children's care in that context.

Response: We appreciate the support of the commenter and also note that the policy, by only permitting twice the usual copayment amount for non-emergency use of the emergency room, protects the lower income populations served by SCHIP from having to pay excessive cost sharing if they find they can only access services at an emergency room. At the same time, it encourages enrollees to receive non-emergency services outside of an emergency room setting.

We realized that the proposed regulation text was not clear regarding the limit on cost sharing related to emergency services. Therefore, we added to section § 457.555(a) that the maximums provided in this section apply to non-institutional services provided to treat an emergency medical condition as well. We also clarified in paragraph (c) that any cost sharing the State imposes on services provided by an institution to treat an emergency medical condition may not exceed $5.00. Finally, we removed paragraph (d) from this section, because the requirement is already included in § 457.515(f).

Comment: Several commenters were concerned about the language in § 457.995(c)(2) which prohibits patients from being held responsible for any additional costs, beyond the copayment amount specified in the State plan, that are associated with emergency services provided by a facility that is not a participating provider in the enrollee's managed care network.

Response: With respect to the issue of additional costs for out-of-network emergency services, we believe that any costs associated with evaluating and stabilizing a patient in an out-of-network facility in a manner consistent with the cost-sharing restrictions in this regulation at § 457.555(d) must be worked out between the State and the managed care entity. Given the nature of the circumstances that may necessitate emergency services, enrollees may not be able to choose their place of care. Thus, the regulations do not allow additional cost sharing to be imposed on the beneficiary for emergency services including those provided out-of-network as described in § 457.515(f)(1) of this final regulation.

Comment: Two commenters asked that we clarify the interpretation of the phrase at § 457.555 (a)(3) and (b) ''directly or through a contract'', with regard to payment made by the State. This commenter interpreted the phrase to mean that when the State operates SCHIP through employer-sponsored health plans, States would be expected to determine the rates paid by those health plans to hospitals and other providers and apply the standards cited in this section to determine allowable cost-sharing limits. The commenter asserted that, if this is HCFA's expectation, these requirements will make it difficult for States to implement SCHIP programs utilizing employer-sponsored health insurance since the State is not the purchaser of health care services in these cases and does not have a legal basis for accessing confidential or proprietary information, such as rates paid by plans to participating providers. The commenter recommended that States that use employer-sponsored insurance be exempt from the requirements proposed of § 457.555 (a)(3) and (b) since these requirements are likely to dissuade many employers from participating in SCHIP.

Response: Any State that contracts with another entity to provide health insurance coverage under the SCHIP program is paying for services through a contract. If a State subsidizes SCHIP coverage other than through a contract, such as in a premium assistance program, the State is still responsible for ensuring that cost-sharing charges to enrollees in such plans comply with this regulation. We recognize that this might require some additional steps but it is important to provide these protections to all SCHIP enrollees uniformly. States, as part of any contract with a health insurer, should request the payment rate information to assure that cost sharing being imposed by the insurer does not exceed the amounts in this section. We are also revising § 457.555(b) to specify that copayments for institutional services cannot exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the service on the first day of institutional care. As previously discussed, employer-sponsored insurance is subject to the same cost-sharing limits as all separate child health programs. This rule applies to both managed care and premium assistance programs.

Comment: One commenter urged HCFA to include language in the preamble to underscore that the philosophy and structure of managed care delivery systems make unnecessary the use of cost sharing to control utilization. HCFA should encourage States to set lower maximum allowable cost-sharing amounts for institutional services.

Response: States have discretion under 2103(e) to impose cost sharing up to the limits established in the statute and in this regulation. We note that many studies have shown that cost sharing does impact utilization in managed care delivery systems. We also note that 50 percent of the cost of the first day of care in an institution may be expensive for families below 150 percent of the FPL. We encourage States to set reasonable limits that take into consideration the income level of these families.

Comment: One commenter supported limiting copayments per inpatient hospital admission, but noted that the current proposal is based on each institutional admission. In this commenter's view, this policy has the potential to promote early release and frequent readmissions that could be detrimental to a child's health. The commenter suggested that cost sharing for institutional admissions be based on a period of time or some other criteria in order to prevent potential inappropriate releases.

Response: Section 2103(e)(3)(A)(ii) limits the imposition of cost sharing to the nominal amounts consistent with regulations referred to in section 1916(a)(3) of the Act. Proposed § 457.555(b) mirrors § 447.54 of the Medicaid regulations regarding institutional services with some clarification for its application in the SCHIP context. We have not found data that supports a pattern of early discharge exists in the Medicaid program due to this provision. Therefore, we will adopt the regulation as proposed, consistent with section 2103(e)(3)(A)(ii) of the Act.

Comment: One commenter indicated that, with regard to institutional services, the proposed regulation states that the cost sharing cannot exceed 50 percent of the payment the State makes directly or through contract for the first day of care in that institution. The commenter stated that, in a managed care context, the State does not pay a per day amount to the managed care entity (MCE). The commenter requested that HCFA clarify how this institutional cost-sharing limitation is to be interpreted in the MCE setting.

Response: We have clarified § 457.555(b) to indicate that cost sharing may not exceed 50 percent of the payment the State would have made under the Medicaid fee-for-service system for the first day of care in that institution. We believe this remains consistent with the legislative intent to keep cost sharing at nominal levels in accordance with Medicaid.

Comment: One commenter observed that the imposition of copayments for emergency room visits that mirror copayments for other services, including

physician or clinic visits ($5.00 copayment) provides a negative incentive. States should have the ability to impose a differential copayment for emergency visits, even if it is minimally higher than that imposed for visits to a primary health care provider.

A commenter stated that, in order to control non-emergency utilization of the emergency room and to smooth the transition of families from SCHIP to commercial insurance coverage, States should be permitted flexibility in establishing the maximum copayment amount for such services and notes that, in some States, amounts up to $25.00 have been permissible. One commenter noted that without differential copayments for emergency room visits, the incentives are aligned to promote use of a primary care model over unimpeded access to emergency rooms.

Response: We have revised § 457.555(a) of the final regulation to specifically require that services provided to an enrollee for treatment of an emergency medical condition shall be limited to the cost schedule under (a) of that section with its maximum of $5.00. We also note that States are not required to charge the maximum amount permitted in § 457.555(a) for a physician service and may choose to impose a lower amount than $5.00 on physician services, providing the incentive for the beneficiary to access services at the physician level before using the emergency room. In addition, § 457.555(c) permits a maximum amount of $10.00 for nonemergency use of the emergency room, which may also create incentives to use the primary health care provider when appropriate.

For the targeted low-income child in a family with income above 150 percent of the FPL, States may impose a higher amount than $5.00 for emergency services provided in an emergency room as long as the family has not paid cost sharing that exceeds the cumulative cost-sharing maximum of 5 percent of the family's income for a year. The regulation only requires that States limit copayments for emergency services provided in the emergency room to the schedule in § 457.555(a) for those children in families with income from 101 to 150 percent of the FPL, and limit such copayments consistent with § 457.540(b) for those children in families with incomes below 100 percent of the FPL.

Comment: A commenter recommended that no arbitrary amount ($10.00) be used as the maximum copayment for non-emergency use of the emergency room. In this commenter's view, if such an amount is included in this section, it should be indexed for inflation.

Response: The maximum copayment amount is based on the statutory requirement that cost sharing for families at or below 150 percent of the FPL must be in accordance with the Medicaid rules. The amount of $10.00 in § 457.555(c) is consistent with § 447.54(b), which allows a waiver of the nominal amount in the Medicaid regulation for nonemergency services furnished in a hospital emergency room up to double the maximum copayment amounts. We have chosen a set limit for the SCHIP enrollees in families with income from 101 to 150 percent of the FPL in lieu of the complicated waiver requirement in Medicaid.

Comment: A commenter agreed that non-emergency use of emergency facilities should be limited. However, the commenter is concerned about doubling the noninstitutional copayment amount permitted when an enrollee uses an emergency room for non-emergency services. The commenter noted that, in many rural areas, access to non-emergency facilities may not be readily available, and argued that families should not be penalized (charged double) when alternative services are not available.

Response: Proposed § 457.735 (now § 457.495) of the regulation requires the State plan to include a description of the methods it uses for assuring the quality and appropriateness of care provided with respect to access to covered services. States must ensure that an adequate number of providers available so families do not need to seek routine treatment in an emergency room.

Comment: Several commenters asked that the regulation clarify that States should use the prudent layperson standard proposed at § 457.402(b) in the assurance that cost sharing for emergency services to managed care enrollees would not differ based on whether the provider was in the managed care network.

Response: We agree that the prudent layperson standard should be applied to this section. In the proposed rule, we defined emergency services at § 457.402(c), to include the evaluation or stabilization of an emergency medical condition. Because this definition is relevant to the entire regulation, we have moved the definitions of emergency services and emergency medical condition to § 457.10. Section 457.10 now defines emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in jeopardizing the individual's health (or in the case of pregnant women, the health of the woman or her unborn child), serious impairment of bodily function or serious dysfunction of any bodily organ or part.

Comment: One commenter suggested that HCFA issue additional guidance on what, if any, sanctions for non-payment of cost sharing can be exercised.

Response: States are allowed flexibility when proposing sanctions. HCFA will review the State sanctions as part of the State plan and consider proposed sanctions on a case-by-case basis. We will require that States, in accordance with § 457.570(b), provide an opportunity for the targeted low-income child's family to have its income reevaluated when the family cannot meet its cost-sharing obligations. The family income may have dropped to a point where the child qualifies for Medicaid, or where the child is in the category of SCHIP enrollees that is subject to lower (or no) cost sharing.

13. Cumulative Cost-Sharing Maximum (§ 457.560)

Section 2103(e)(3)(B) of the Act provides that any premiums, deductibles, cost sharing or similar charges imposed on targeted low-income children in families above 150 percent of the FPL may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family may not exceed 5 percent of the family's income for the year involved. We refer to this cap on total cost sharing as the cumulative cost-sharing maximum.

We proposed two general rules regarding the cumulative cost-sharing maximums. First, a State may establish a lower cumulative cost-sharing maximum than those specified in § 457.560(c) and (d). Second, a State must count cost-sharing amounts that the family has a legal obligation to pay when computing whether a family has met the cumulative cost-sharing maximum. We proposed to define the term ''legal obligation'' in this context as liability to pay amounts a provider actually charges the family and any other amounts for which payment is required under applicable State law for covered services to eligible children, even if the family never pays those amounts.

We proposed that for children in families above 150 percent of the FPL, the plan may not impose premiums,

enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate exceed 5 percent of total family income for a year (or 12 month eligibility period).

We proposed that for targeted low-income children in families at or below 150 percent of the FPL, the plan may not impose premiums, deductibles, copayments, co-insurance, enrollment fees or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period.

Comment: A number of commenters disagreed with the proposed definition of ''legal obligation'' for use in connection with counting cost-sharing amounts against the cumulative cost-sharing maximum. They noted that it is very difficult and time-consuming to track payments that have not occurred. One commenter suggested changing the definition of the term ''legal obligation'' to only those ''cost-sharing amounts, which families have actually paid.''

Response: States may rely on documentation based upon provider bills that indicate the enrollee's share rather than relying only on evidence of payments made by the enrollee. We have not adopted the commenters' suggestion because this could result in families being legally obligated to pay cost-sharing amounts in excess of the cumulative maximum.

Comment: One commenter asked if this provision means that for any and all out-of-network health services, (provider charges in excess of the amount paid by the health plan) must count toward the family's cumulative cost-sharing maximum. The commenter noted that no private health plans work this way, especially employer-sponsored plans. According to this commenter, a requirement to recognize out-of-network provider charges would greatly complicate this process by requiring States to verify that provider bills submitted by families as evidence of having reached the maximum were not in fact paid by the health plan in which the children are enrolled.

Response: If an enrollee has been authorized by his or her health plan to receive out-of-network services, then the associated charges must comply with these rules and be counted toward the cumulative cost-sharing maximum. In addition, an enrollee's costs incurred for emergency services (as defined at § 457.10) furnished at an out-of-network provider also count toward the cumulative cost-sharing maximum. The regulation does not require coverage of out-of-network services that are not authorized, except for emergency services. Therefore, States are not required to count costs of unauthorized services received out-of-network toward the cumulative cost-sharing maximum.

Comment: One commenter recommended that States be able to retain the flexibility to define the year for purposes of cost sharing as the insurance benefit year for group insurance rather than an individual family's eligibility period as proposed. In this commenter's view, the use of individual family eligibility periods would be an ''administrative nightmare.''

Response: States may apply the cumulative cost-sharing limits based on the insurance benefit's 12 month period for group insurance. In that case, for families that enroll during the benefit year, the State must calculate the cumulative cost-sharing maximum based on the income of the family only for the period of time the beneficiary is actually enrolled within that benefit year.

Comment: One commenter noted that these rules allow a State to count cost-sharing amounts that the family has a legal obligation to pay. The commenter indicated that as section 330 Public Health Service grantees, Federally qualified health care centers (FQHCs) are required to prepare a schedule of fees or payments for incomes at or below those set forth in the most recent FPL. They also noted that health centers are obligated to charge patients on a sliding scale basis if their income is between 100 and 200 percent of the FPL. Therefore, the commenter stated that, based on this proposed rule, health center patients will not receive cost-sharing credits for that portion of the copayments that the health center is expected to waive under a sliding fee schedule policy.

The commenter requested that HCFA provide an exception to consider SCHIP patients served in FQHCs as having paid the full highest possible copay cost of the copayment in calculating the cumulative cost-sharing maximum, whether or not they were charged this amount. In addition, the commenter indicated that SCHIP plans should be instructed that, if a FQHC normally charges its patients with incomes between 100 and 200 percent of the FPL on a sliding scale basis, it should not be required or expected to apply a cost-sharing charge to a SCHIP patient that would exceed its sliding scale discount. For example, if the health center charge for a service is $100.00, but it only charges $50.00 for those with incomes between 150 percent and 200 percent of the FPL, it should only charge 50 percent of the allowable copayment for patients covered under SCHIP, in this commenter's view.

Response: States are only obligated to count towards the cumulative cost-sharing maximum the amounts that a patient has a legal obligation to pay. Therefore, States may not count the amounts that the health center covers towards the maximum. The State is only obligated to count what the SCHIP patient is actually charged by the health center for purposes of the cumulative cost-sharing maximum. However, we do agree that the FQHC should not charge the enrollee more than is permissible under the FQHC's sliding scale, nor should it charge the enrollee more than is permissible under the SCHIP program.

Comment: Several commenters requested that we reconsider the 2.5 percent cumulative cost-sharing maximum. They raised specific concerns regarding the 2.5 percent cumulative cost-sharing maximum, including: The provision is not supported by the statute; it is very difficult to administer two caps (2.5 percent and 5 percent) and track against two caps; limits on copayments and deductibles are already found in § 457.555 and section 2103(e)(3)(A) of the Act; States have already implemented flat cumulative cost-sharing maximums that are administratively efficient and provide families with fluctuating incomes greater stability; HCFA's commissioned study by George Washington clearly demonstrates that it is rare that enrollees will reach the 5 percent cost-sharing maximum; and when a limit is set using a percentage, there is no need to make the percentage less.

One of the commenters also noted that the Medicaid maximum charges for premiums and other cost-sharing charges, which apply to families at or below 150 percent of the FPL, are minimal in amount and are not based upon income or family size. As a result, the addition of another level of cost sharing (2.5 percent) adds to an already complex cost-sharing structure, in this commenter's view. The commenter added that such requirements are virtually impossible to implement in a program that subsidizes employer sponsored insurance.

Response: We disagree with the commenters. A lower cost-sharing maximum on children is necessary in order for States to comply with the requirements at section 2103(e)(2)(B), which require that separate child health plans may only vary cost sharing based on the family income of targeted low-income children in a manner that does not favor children in families with

higher incomes over children in families with lower incomes. If the State does not want to administer two caps, it does have the option to place the 2.5 percent cap or a flat amount equal to 2.5 percent of the family's income on the entire enrollee population that is subject to cost sharing. This should have a minimal impact on the amount of cost sharing States will impose; particularly in light of the George Washington University study, as indicated by the commenter, which found that it is rare for families to reach the 5 percent cap at all. The State may also choose to impose premiums instead of copayments, coinsurance or deductibles, so that tracking of cost sharing is not necessary.

Comment: One commenter noted that the separate calculation requirement applied to each beneficiary's family to ensure that the five percent cost-sharing limitation is met is unwieldy and expensive. In this commenter's view, it is unlikely that opportunities for participation in premium assistance programs will be aggressively pursued. The commenter also asserted that our policy eliminates the opportunity for children in SCHIP to be enrolled in premium assistance programs.

Response: For targeted-low income children in families with income greater than 150 percent of the FPL, section 2103(e)(3)(B) requires States to ensure that cost sharing does not exceed 5 percent of a family's income. The statute does not exempt States from this cap if they provide child health assistance through an employer-sponsored insurance program. Therefore, we have not included any exceptions to the rules for States utilizing premium assistance programs.

Comment: One commenter stated that the regulation goes beyond legislative intent by requiring that copayments and deductibles be included in the computation of the maximum cost sharing for a family with income above 150 percent of the FPL. In support of this point, the commenter noted that section 2103(e)(3)(B) of the Social Security Act limits ''enrollment fees, premiums, or similar charges'' to five percent of the family's income. The commenter asserted that deductibles and copayments are not ''similar charges,'' because they are not prepayments for benefits coverage; rather, they are payments made to treating providers at the time of service delivery. By requiring States to include deductibles and copayments in the calculation of the maximum, HCFA has created major administrative problems, especially for the majority of states that are using HMOs or other insurers in this commenter's view. The commenter recommended that we limit the calculation of the maximum amount to ''enrollment fees, premiums and similar charges''. The State merely has to make sure it sets a premium below the maximum of 5 percent of family income.

Response: Section 2103(e)(3)(B) of the Act provides that ''any premiums, deductibles, cost sharing, or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggregate cost sharing with respect to all targeted low-income children in a family under this title may not exceed five percent of such family's income for the year involved.'' The statute's reference to ''deductibles, cost sharing, and similar fees'' clearly indicates that the charges to be counted towards the cumulative cost-sharing maximum are not to be limited to premiums and enrollment fees. However, States have the option to impose only premiums under their SCHIP plans.

Comment: One commenter noted an error in this section. Specifically, the commenter pointed out that the proposed regulation text states that total cost sharing imposed on families with incomes above 150 percent of the FPL not exceed the maximum permitted under § 457.555(c). It should be § 457.560(c).

Response: The commenter is correct that the reference should have been to § 457.560(c). In addition, in order to eliminate this confusion and redundancy in the final regulation text, we have eliminated section § 457.545 and reflected the policy at § 457.560(c).

14. Grievances and Appeals (§ 457.565)

We proposed that the State must provide enrollees in a separate child health plan the right to file grievances and appeals in accordance with proposed § 457.985 for disenrollment from the program due to failure to pay cost sharing. We address comments on proposed § 457.565 in subpart K, Enrollee Protections, which now contains the provisions relating to applicant and enrollee protections. We have deleted proposed § 457.565 in an effort to consolidate all provisions relating to the review process in the new subpart K.

15. Disenrollment Protections (§ 457.570)

Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Based upon this provision of the statute, we proposed in § 457.570 to require that States establish a process that gives enrollees reasonable notice of, and an opportunity to pay, past due cost-sharing amounts (premiums, copayments, coinsurance, deductibles and similar fees) prior to disenrollment. We requested comments on this requirement, including specific comments on the determination of an amount of time that would give enrollees reasonable notice and opportunity to pay cost-sharing amounts prior to disenrollment. We stated that we would request that States with approved plans submit this additional information after publication of the proposed rule and prior to the State's onsite review. We stated that we would also ask the State to include a description of its process in future amendments to its State plan.

Comment: One commenter noted that disenrollment occurs in the Hispanic population because the SCHIP process is extremely paper-intensive. In this commenter's view, one of the most common reasons for disenrollment from SCHIP is the termination of benefits due to the failure to provide premium payments in a timely manner. They stated that, Hispanics in eligible income brackets, in particular, tend to deal in a cash economy, making it difficult to pay SCHIP premiums in the preferred method of payment. In order to slow disenrollment the commenter stated that it is necessary to devise a plan to eliminate the barrier to payment, and effectively reduce the rate of disenrollment among Hispanics.

Response: The SCHIP statute specifically allows States to impose premiums on the SCHIP population within statutorily defined limits. However, we encourage States to be flexible in the methods of payment permitted for cost-sharing charges and to allow grace periods and to provide adequate notice when payments are not made. We have clarified in the final rule that the State plan must describe the disenrollment protections provided to enrollees. In addition, States might monitor disenrollments by reason for disenrollment and determine whether certain groups of enrollees are more likely than others to lose coverage due to failure to meet the cost-sharing requirements. In addition, we encourage States to work with advocates from the Hispanic community to devise culturally sensitive methods to inform consumers about cost sharing and

devise appropriate procedures for obtaining necessary premium payments.

Comment: One commenter noted that the appeals procedures should not be structured in such a way as to give a child's family an incentive to drop SCHIP coverage for a child until he or she needs health services. This practice undermines basic insurance principles and threatens the financial integrity of SCHIP programs because it would result in the pool of enrollees being significantly more sick and more costly than would otherwise be anticipated, in this commenter's view. They stated that the result of such a practice would be to unnecessarily increase the costs of providing coverage to enrollees, which in turn would potentially threaten the viability of the State's SCHIP. The commenter recommended that HCFA revise the regulation to require States to address this issue when they define the circumstances under which a member will be permitted to re-enroll following voluntary disenrollment or disenrollment for nonpayment of premiums or cost sharing.

Response: We are aware that there may be problems when an enrollee is disenrolled and permitted to re-enroll. Some States have adopted lock-out periods to promote the appropriate utilization of health insurance, although other States have discontinued their lock-out periods because they did not find any significant increase in sicker enrollees. States have the flexibility to design their programs based on their unique circumstances to assure that eligible enrollees maintain coverage.

Comment: Many commenters agreed that enrollees should be given an opportunity to pay past due cost sharing prior to disenrollment. Many commenters noted that there should not be any lock-out periods, that States should give families every opportunity to pay past due premiums and at a minimum, grant grace periods of 60 days for the non-payment of premiums. One commenter suggested that the preamble urge States to conduct a Medicaid screen if a child's family is unable to pay premiums due to financial hardship.

Response: We agree that, at the very least, a State should give enrollees a chance to pay past due cost sharing prior to disenrollment. While many commenters noted that lock-out periods should not apply, it is appropriate to allow States to implement a lock-out period so that individuals are not obtaining or maintaining SCHIP coverage only when they need services. We also agree with the comment encouraging States to perform a Medicaid eligibility screen for enrollees who are unable to pay cost-sharing charges due to financial hardship and have emphasized this elsewhere in comments to this final rule. We have added that the disenrollment process must afford enrollees the opportunity to show that their family income has declined prior to being disenrolled for nonpayment of cost-sharing charges. In the event that such a showing indicates that the enrollee may have become eligible for Medicaid or a lower level of cost sharing under separate child health plans, States should take action to either enroll the child in Medicaid or adjust the child's cost sharing category. We expect this new protection will afford enrollees the opportunity to enroll in Medicaid if they have become eligible.

Comment: A few commenters noted specific standards regarding disenrollment protections that HCFA should articulate in the final regulation. Specifically, the commenter recommended that HCFA clearly define what constitutes reasonable notice; clarify that only the State may disenroll a child or impose any other sanction due to an enrollees's failure to pay cost sharing; provide that disenrollment can only be effected after all reasonable steps have been undertaken to avoid disenrollment; require that families should be offered the opportunity to establish a repayment plan; and that families cannot be subjected to penalties or interest for past due payments.

Response: The regulation at § 457.570 regarding disenrollment protections provides enrollees with meaningful protections in connection with any disenrollment related to cost sharing while giving the States flexibility to establish processes consistent with the goals and structure of their programs. We do not accept the commenter's recommendation that HCFA be prescriptive in the regulation regarding disenrollment protections, because each State's SCHIP program is separate and distinct and should retain flexibility accordingly.

Comment: One commenter noted that States should be given the flexibility to decide how they will implement this standard. Specifically, this commenter believes it is administratively burdensome to track a specific grace period before a family is disenrolled from SCHIP.

Response: States are granted flexibility to establish disenrollment procedures under § 457.570 of the final rule. These procedures must be included as part of the State plan. However, the rule does require States to provide reasonable notice prior to disenrollment and provides for a period of time (grace period) for the enrollee's family to pay past due amounts. The rule also enables the State to evaluate the enrollee's financial situation prior to disenrollment to ensure he or she does not qualify for Medicaid.

Comment: One commenter complained that the proposed disenrollment protections were too burdensome because they do not permit disenrollment for nonpayment of premiums even after reminder notices have been sent. One commenter noted that implementing a grace period before disenrollment will result in duplicative coverage and wasted funding since research shows that the primary reason a family fails to pay its monthly premium is that the family has obtained other coverage.

Response: The regulation at § 457.570 regarding disenrollment protections gives the States flexibility to establish processes consistent with the goals and structures of their programs. A disenrollment process without any grace period could result in a system that would disenroll a family prematurely (without adequate notice) and interrupt the family's continuity of care. Therefore, we continue to require that States establish a process that gives enrollees reasonable notice of, and an opportunity to pay past due premiums, copayments, coinsurance, deductibles, or similar fees prior to disenrollment.

Comment: One commenter noted that there may be cases in which the individual responsible for paying a premium is not the custodial party or head of household for the children. In such cases, the commenter stated that notices of disenrollment for failure to pay a premium need to be provided to both the payer of the premiums and the SCHIP beneficiary. Also, if premiums are owed by an individual other than the head of household, and are not paid, the family receiving the SCHIP benefits should not be subject to penalties, and should be given an opportunity to assume responsibility for making future payments.

Response: We agree with the commenter and recommend that States review all viable financial options of an enrollee prior to disenrolling an enrollee due to a parent or caretaker's failure to pay cost sharing. We will also require that States include a disenrollment policy as part of its public schedule, so that all family members who are responsible for paying cost sharing on behalf of the enrollee are informed of the disenrollment process.

F. Subpart G—Strategic Planning, Reporting, and Evaluation

1. Basis, Scope, and Applicability (§ 457.700)

As proposed, this subpart sets forth the State plan requirements for strategic planning, monitoring, reporting, and evaluation under title XXI. Specifically, this subpart implements sections 2107(a), (b), and (d) of the Act, which relate to strategic planning, reports, and program budgets; and section 2108 of the Act, which sets forth provisions regarding annual reports and evaluations.

In the preamble to the proposed rule, we noted the importance of reporting and evaluating SCHIP data. We stated that these activities will provide the critical information necessary for meeting Federal reporting requirements, documenting program achievements, improving program function, and assessing program effectiveness in achieving policy goals. We also described that our information dissemination policy will include making State annual reports, State evaluations and a summary of State expenditures and statistical reports regularly available on the Internet.

Comment: Several commenters strongly supported the statement in the preamble to proposed § 457.700 indicating that we plan to make annual reports, State evaluations, and summaries of State reports regularly available for public access on the Internet. One commenter recommended that an annual, separate, consumer-friendly SCHIP State-by-State status report be available in written and electronic form to the public.

Response: We plan to continue the information dissemination policy that includes making annual reports, State evaluations, and a summary of State expenditures and statistical reports regularly available on the Internet, to the maximum extent possible. We have already produced two State-by-State reports on SCHIP enrollment and released a summary of the States' March 31, 2000 evaluations. We plan to produce and make available future informational reports based on State evaluations, enrollment data, and other sources. We encourage the public not only to access our web site to read the State annual reports and other State-specific information but also to access individual State web sites. In addition, we note that several national organizations, such as the National Governors' Association (NGA), the National Academy for State Health Policy (NASHP), the Children's Defense Fund, the National Conference of State Legislators (NCSL), the American Public Human Services Association (APHSA), the American Academy of Pediatrics (AAP), and other organizations representing State and local governmental entities periodically produce State-by-State SCHIP status or informational reports that are available to the public. We encourage the public to utilize these resources.

Comment: Several commenters stated that we should require States to collect information in a manner that does not discourage individuals from applying for SCHIP. Techniques suggested for achieving this goal include: explaining to participants the purpose of the information collected, assuring confidentiality of information collected, and disclosing that the failure to provide the requested information will not be used to deny eligibility.

Response: We agree with commenters on the importance of gathering evaluative information without creating barriers to participation in SCHIP; and we know this is a concern for States and other stakeholders who have worked to simplify and streamline the application process. We also recognize the flexibility given to States in creating and evaluating their uniquely designed SCHIP programs. We encourage States to be mindful of potential barriers created by collecting information and to create systems that do not prevent potential enrollees from applying for health insurance coverage under SCHIP.

In addition, as noted later in the responses to comments on §§ 457.740 and 457.750, in conjunction with the requirement that States collect and report information about the gender, race, ethnicity and primary language of SCHIP enrollees; we emphasize the importance of States ensuring through the application process that failure to provide information on one of these areas will not affect a child's eligibility for the program. In addition, States must request this information in a manner that is linguistically and culturally appropriate so as not to discourage enrollment in the program.

2. State Plan Requirements: Strategic Objectives and Performance Goals (§ 457.710)

In accordance with section 2107(a) of the Act and the Government Performance and Results Act of 1993 (GPRA), proposed § 457.710 encouraged program evaluation and accountability by requiring the States to include in their State plan descriptions of the strategic objectives, performance goals, and performance measures the State has established for providing child health assistance to targeted low-income children under the plan and for otherwise maximizing health benefits coverage for other low-income children and children generally in the State.

In accordance with section 2107(a)(2) of the Act, we proposed at § 457.710(b) that the State plan must identify specific strategic objectives related to increasing the extent of health coverage among targeted low-income children and other low-income children. We encouraged States to view the development of strategic objectives as a process that involves translating the basic overall aims of the State plan into a commitment to achieving specific performance goals or targets, recognizing that there will be variation among States in specific evaluation approaches and terminology. One of the strategic objectives established in the Act is the reduction in the number of low-income, uninsured children.

Under section 2107(a)(3) of the Act, States must identify one or more performance goals for each strategic objective. We proposed to implement this statutory provision at § 457.710(c). We noted in the preamble that detailed performance goals should facilitate the State's ability to assess the extent to which its strategic objectives are being achieved. In addition, we provided guidance on factors States should consider in drafting strategic objectives and performance goals, noting that they should consider not only the general population targeted for SCHIP enrollment, but special population subgroups of particular interest as well.

In accordance with section 2107(a)(4) of the Act, proposed § 457.710(d) provides that the State plan must describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals. We set forth specific examples of acceptable performance measures in the preamble to the proposed rule.

Comment: We received several comments suggesting that we require States to report on a common core of widely-used, objective, standardized, and child-related performance measures and strategic objectives designated by the Secretary. Furthermore, commenters recommended that we require the results of these standard performance measures to be included in the States' annual reports. Some commenters feared that, absent a requirement to report a common set of measures, the information collected might be meaningless and could not be used to evaluate or compare the effectiveness of State plans.

Commenters recommended strategic objectives including: the need to reduce and/or eliminate racial and ethnic disparities in children's health insurance coverage; the need to reduce and/or eliminate barriers to health coverage for children with disabilities; the need to reduce stigma and barriers to access in Medicaid; the need to ensure that the goal of increasing coverage for uninsured children does not supplant or overshadow the importance of ensuring that the receipt of health benefits coverage results in the provision of quality health care and improves health outcomes. Commenters believed that HCFA should consult with the States in creating these national standards, and in doing so, build upon the efforts of other Federal agencies, such as the performance measures developed for State Maternal and Child Health Services Block Grants by the Health Resources and Services Administration.

Response: We agree there should be a common core of evidence-based, standardized, child-related performance measures and performance goals. These measures and goals can be used to evaluate the overall effect of the program in access, service delivery, processes of care and health outcomes with the intent of improving the quality of care, particularly in the areas of well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations. Section 2701(b)(1) of the Act and proposed § 457.20 directs that State plans must include assurances that the State will collect data, maintain records, and provide reports to the Secretary at the times and in the format the Secretary may require. The development of common quality and performance measures and goals is essential to assessing the national impact of the SCHIP program and we have modified the regulation text at § 457.710(d)(3) to provide that the Secretary may prescribe a common core of national measures.

However, we also acknowledge the difficulties in achieving national consensus on specified measures. Therefore, HCFA will convene a workgroup to develop a set of core performance measures and performance goals incorporating appropriate quality assurance indicators, and the methodology for implementing common measures and goals for SCHIP in an appropriate and timely manner. As we undertake this effort, we will be guided by the objectives, goals and measurement methods States have developed, as described in their annual reports and evaluations.

The development of national performance indicators and goals does not diminish the importance of having States identify their own specific strategic objectives, and accompanying performance goals and measurements. While States may be required to adopt national performance measures and goals once they have been developed, we expect States to implement their own performance measures, performance goals and strategic objectives specific to the unique design and priorities of their own program. States, in accordance with section 2107(a)(4) of the Act, will continue to be required under § 457.710 to establish State-specific performance measures and to describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals.

Comment: One commenter suggested that HCFA recommend to States the following outcome measures: out-of-home placements, the Children and Adolescent Functional Assessment Scale (CAFAS), days-in-school, school performance, and reduced involvement in the legal system.

Response: We agree with the commenter that measures from a variety of sources can be useful in evaluating the impact of SCHIP on the health and the behavior of participants and we would encourage States to take them into consideration as they develop their State-specific performance measures. Additionally, as we convene a workgroup to discuss the development of national core performance and quality assessment measures, we will consider the measures the commenter has suggested. We are mindful, however, that SCHIP's first goal is to expand coverage to uninsured children and that, while it is generally believed that coverage and better access to health care can lead to improvements in school attendance and school achievement, it is difficult to isolate the cause and effect of changes in social behavior that are influenced by a wide range of factors and circumstances.

Comment: We received one comment expressing concern that the willingness and ability of managed care entities (MCEs) to participate in SCHIP depended on whether the revenues adequately covered the MCEs' costs. The commenter noted that costs associated with collecting and validating data may be substantial, and thus may prevent MCEs' from participation in the program. The commenter expressed concern that the MCE might not have a large enough population of SCHIP participants to generate statistically valid data. Additionally, the commenter asserted that HCFA has failed to establish realistic goals for Quality Improvement System for Managed Care (QISMC)-related health plan activities and performance that take into consideration available resources and responsibilities for the delivery of quality care for beneficiaries.

Response: We recognize the concerns expressed by the commenter. However, we disagree that the requirements in the proposed regulation may impose an undue financial hardship upon MCEs. This regulation provides States with significant flexibility regarding the performance measurements they will use and the preamble to the proposed rule encouraged States to review measures, including those widely used by private-sector purchasers of MCE services. We suggested in the preamble of the NPRM that States may wish to consider adopting standardized methods and tools in quality assurance and improvement, such as those of the QISMC initiative, but we did not propose and are not requiring the use of QISMC-related measures. However, the burden on MCEs would be minimized to the extent a State chooses measures that the MCEs are already using in connection with other programs.

In any event, the regulation imposes obligations on States and does not directly govern actions of MCEs. While we require States to report data relating to their strategic objectives and specific performance goals, we are aware of the difficulty in compiling statistically valid data in small sample sizes and are mindful of States' interest in reducing burden for their MCEs. The regulation does not require that States collect encounter data. States have the option of choosing other methods of collecting data related to their strategic objectives, including, but not limited to, surveys of SCHIP participants and/or SCHIP health care providers and looking at encounter data, to the extent it is available.

Comment: One commenter urged HCFA to include the American College of Obstetricians and Gynecologists educational bulletin entitled ''Primary and Preventive Health Care for Female Adolescents'' in the list set forth in the preamble of examples of widely recognized measures and guidelines states should review in developing performance measures for SCHIP programs.

Response: We agree with the commenter that there may be several measures beyond those we specifically mentioned in the preamble to the proposed rule that States might find helpful in translating their strategic

objectives into performance measures and goals. We encourage States to consider this bulletin as well as others that provide widely-used performance measures for children's and adolescent's health and health care.

Comment: A couple of commenters indicated that while the Health Employer Data and Information Set (HEDIS) was designed to be reported at the health plan level, plan-reported numerators and denominators can be added together to yield aggregate State-level reports that could help measure performance in reaching State enrollment targets and in delivering high quality health care. The commenters indicated that HEDIS measures are objective, validated measures of health plan performance (on quality, access and availability, and the use of services) and, when audited using the HEDIS Compliance Audit, performance measures are independently verified. In addition, the commenters stated that national benchmarks exist for both the commercial and Medicaid populations which can be used to establish performance goals and to evaluate performance of a specific health plan or State SCHIP program. One commenter noted that the National Committee on Quality Assurance (NCQA) offered to work with HCFA and States on implementation strategies, including making HEDIS specifications broadly available.

Response: We agree that HEDIS may be a useful tool for States in measuring their performance and establishing goals. We appreciate NCQA's willingness to assist with SCHIP implementation and are working with them to develop HEDIS specifications for SCHIP. In States that are considering using HEDIS measures, we have recommended the following approach to reporting data and information on SCHIP programs: Where a State contracts with managed care entities (MCEs) for health benefits coverage for SCHIP enrollees, States should, where possible, identify individual SCHIP enrollees for its contracting MCEs as detailed below.

If the State has identified SCHIP enrollees to a contracting MCE, and the contracting MCE also contracts with the State Medicaid program, then the MCEs should, as directed by the State either: (1) report the required HEDIS measures separately for SCHIP enrollees; or (2) include SCHIP enrollees in their Medicaid product line reports.

If the State has identified SCHIP enrollees to a contracting MCO and the contracting MCE is a commercial MCE without a Medicaid product line, the MCE should exclude SCHIP enrollees from its commercial product line reports, because including SCHIP enrollees in HEDIS reports for commercially enrolled populations may affect commercial MCE-to-MCE comparisons. Under these circumstances, HEDIS performance measures for SCHIP enrollees will need to be reported separately. In addition, MCEs with small numbers of eligible SCHIP enrollees should follow the small numbers general guideline. These specifications will be included in the HEDIS guidelines for 2001.

Comment: In response to HCFA's solicitation for comments on additional measures that will assist in articulating the success of programs implemented under title XXI, several commenters recommended the following performance measures:

Access

—Percentage of Medicaid eligible enrolled in Medicaid;
—Percentage of SCHIP eligible enrolled in SCHIP;
—Percentage of children with a usual source of health care;
—Percentage of children with an unmet need for physician services and/or delayed care;
—Reduction of hospitalization for ambulatory sensitive conditions;
—Percentage of enrollees who are enrolled for a year or more;
—Percentage of children who are identified as having special health care needs;
—Percentage of employers offering health insurance coverage to employees and dependent children;
—Percentage of enrollees whose parents decline employer-sponsored dependent health insurance coverage;
—Percent of children whose eligibility switches between title XIX and title XXI who enroll in the appropriate program (or who maintain health insurance coverage);
—Percentage of pediatricians, family physicians, and dentists who participate in Medicaid and SCHIP;

Process

—Percentage of children and adolescents who have received immunizations according to the ACIP/American Academy of Pediatrics recommended immunization schedule;
—Percentage of children and adolescents who have received all of the well-child visits appropriate for their ages, based on the American Academy of Pediatrics Recommendations for Pediatric Health Care;
—Percentage of adolescents ages 12 though 18 who were counseled for symptoms or risk factors for STDs;
—Percentage of children ages four through 18 during the reporting year who received a dental examination during that year;
—Percentage of children ages three through six who received a vision screening examination during the reporting year;
—Percentage of children and adolescents with all of the well-child visits provided at one health care site during the reporting year;
—Percentage of children and adolescents, parents or caretakers with difficulty communicating with health care professionals because of a language problem or difficulty understanding health care professionals;
—Percentage of children and adolescents with asthma who regularly use a peak flow meter during the reporting year, regularly use a spacer with a metered dose inhaler, and/or who received influenza vaccine during the reporting year;
—Percentage of children with special health needs who received care during the reporting year;

Outcomes

—Rate of hospitalization for ambulatory sensitive conditions such as asthma, diabetes, epilepsy, dehydration, gastroenteritis, pneumonia; or urinary tract infection (UTI);
—Rate of hospitalization for injuries;
—Percentage of children and adolescents reporting days lost from school due to health problems;
—Percentage of children reporting risky health behaviors including injuries, tobacco use, alcohol/drug use, sexual behavior, poor dietary behavior, lack of physical activity;
—Percentage of adolescents reporting attempted suicides;
—Percentage of children reporting unmet medical needs;
—Percentage of children reporting unmet vision needs;
—Percentage of children reporting unmet dental needs; and
—Percentage of family income used for medical and dental care.

Response: Assessments of the impact of the title XXI program on children's health insurance coverage, access to care and use of health care services will occur on both the State level and national levels. On the State level, we would encourage States to consider the commenters' suggested performance measures as they identify those measures which are appropriate for each

of their strategic objectives as required under section 2107(a)(3) of the Act and § 457.410(b).

Nationally, as HCFA works to develop a common core of standardized child-related performance measures, performance levels and quality measures that can be used to evaluate access, service delivery, processes of care, health outcomes and quality in the overall SCHIP program, we will consider the performance measures recommended by the commenters.

3. State Plan Requirement: State Assurance Regarding Data Collection, Records, and Reports (§ 457.720)

Section 2107(b)(1) of the Act requires the State plan to provide an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format that the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. We proposed to implement this statutory provision at § 457.720.

We did not receive any comments on this section and are therefore implementing the provision as proposed.

4. State Plan Requirement: State Annual Reports (§ 457.730)

Section 2107(b)(2) of the Act discusses the requirement that the State plan include a description of the State's strategy for the submission of annual reports and the State evaluation.

Accordingly, we proposed to implement this provision at § 457.730. We noted that, in order to facilitate report submission, a group of States worked with staff from the National Academy of State Health Policy (NASHP), with HCFA representation, to develop an optional model framework for the State evaluation due March 31, 2000 and for subsequent annual reports. We also noted that we would permit States to submit their FY 1999 annual report and their State evaluation on March 31, 2000, together as one comprehensive document. However, since the States evaluations/annual reports have all been submitted, this provision is unnecessary and has been deleted from the final rule. In addition, we have moved the discussion of the annual report requirements to comments and responses on § 457.750.

Comment: One commenter recommended that we require States to use a designated framework for submitting annual reports and evaluations. This commenter suggested that we include clinicians, child advocates and research groups to participate in the development of frameworks for future reports.

Response: While we do not believe it is necessary to require a designated framework for annual reports and evaluations, in order to facilitate report submission, a group of States worked with staff from NASHP and with representatives from HCFA to develop an optional model framework for the State evaluation due March 31, 2000. This framework was finalized and sent to every State and territory with an approved State plan. All States that have submitted their State evaluations have voluntarily used this framework as the basis for their evaluation, although several States supplemented their evaluations with additional data. We currently are in the process of analyzing and synthesizing the data submitted in these evaluations. We will continue to work with States and other interested parties to support these efforts to promote ease of reporting and to facilitate analysis and comparison of important data reported by States on their programs.

NASHP has subsequently developed a similar framework for the annual reports that States will be submitting in January 2001. As SCHIP development continues, we encourage continued participation in the evaluation process by interested researchers, health care providers and provider groups, advocates and advocacy groups, insurance providers, State and local government officials, and other interested parties and intend to keep the process as open and collaborative as possible.

5. State Expenditures and Statistical Reports (§ 457.740)

We proposed to require that the States collect required data beginning on the date of implementation of the approved State plan. We proposed that States must submit quarterly reports on the number of children under 19 years of age who are enrolled in separate child health programs, Medicaid expansion programs, and regular Medicaid programs (at regular FMAP) by age, income and service delivery categories. In the preamble, we noted that the Territories are excepted from the definition of ''State'' for the purposes of quarterly statistical reporting. We also proposed to require that thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for that Federal fiscal year of children who were ever enrolled in the separate child health program, the Medicaid expansion program and the Medicaid program as appropriate by age, service delivery, and income categories.

We proposed that the age categories that must be used to report the data are: under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age. We further proposed to require States to report enrollment by the service delivery categories of managed care, fee-for-service, and primary care case management.

We noted in the proposed regulation and explained in the preamble that States must report income by using State-defined countable income and State-defined family size to determine Federal poverty level (FPL) categories. We proposed that States that do not impose cost sharing and States that only impose cost sharing based on a fixed percentage of income (such as 2 percent) in their Medicaid expansion program or their separate child health program must report their SCHIP and Medicaid enrollment by using two categories: at or below 150 percent of the FPL and over 150 percent of FPL. States that impose cost sharing at defined income levels (for example, at 185 percent and over of FPL) in their Medicaid expansion programs and/or separate child health programs would be required to report their Medicaid and SCHIP enrollment by poverty level (that is, countable income and household size) categories that match their Medicaid expansion program and separate child health program cost-sharing categories. We proposed to require enrollment reporting by income for Medicaid as well as for SCHIP.

We proposed that required standardized reporting be limited to expenditure data and enrollment data as reported by age, poverty level, and service delivery category. We noted in the preamble to the NPRM that States should collect other relevant demographic data on enrollees such as gender, race, national origin, and primary language and that collecting such data will encourage the design of outreach and health care delivery initiatives that address disparities based on race and national origin.

We stated that we were working to develop an option for States to provide the needed SCHIP data through existing statistical reporting systems in the future.

Comment: One commenter suggested that we revise the regulations to specify that a State's failure to submit the statistical reporting forms would ordinarily be considered substantial non-compliance.

Response: Section 457.720 requires States to comply with data reporting

requirements. Section 2106(d)(2) of the statute and § 457.204(c) provide the Secretary with authority to enforce these and other requirements. We do not believe that it is necessary to specify more specific sanctions for non-reporting or delayed reporting within the rule.

We are working closely with States to develop and implement data tracking and reporting systems. SCHIP reporting may involve creating new systems or adjusting existing systems to collect data which can then be reported to DHHS and we recognize that the reporting changes required in this final rule may require further changes to these systems. We will work with the States to accommodate individual needs for technical assistance during the transition.

In the past, some States have had difficulty reporting data to us in a timely matter due to systems constraints. However, we anticipate that many of these difficulties will be resolved in the near future. We recently implemented a new, more easily accessible web-based data reporting system (the Statistical Enrollment Data System (SEDS)) that all States can access through the Internet, rather than through the main frame system. We have also revised the reporting instructions to clarify definitions in a way that will be more clear for States and provide for more standardized reporting among the States. We released these new instructions with a letter to State Health Officials on September 13, 2000. In addition, we are continuing a comprehensive evaluation of possible modifications to the Medicaid Statistical Information System (MSIS), which captures State eligibility and claims records on a person-level basis. The modifications will give States the option of using MSIS to supply the data elements that will meet the title XXI quarterly statistical reporting requirements. We look forward to working with States to further improve the time lines and quality of required SCHIP data. In addition, we have added a new reporting line to the quarterly reports where States indicate a ''point in time'' enrollment count that indicates enrollment as of the last day of the quarter for their SCHIP and title XIX Medicaid programs. This count is something the States already have available for their own purposes and helps provide a more complete picture of States' programs on an ongoing basis.

Comment: We received several comments requesting that HCFA require States to collect data pertaining to one or more of the following categories of information about enrollees and their SCHIP coverage: gender, ethnicity, race, primary language, English proficiency, age, service delivery system, family income, and geographic location. Certain commenters suggested that this data be collected and reported to HCFA in the State evaluations, annual reports, and/or quarterly statistical reports. These commenters felt this information would help target outreach, retention, enrollment, and service efforts to under-represented groups. These commenters also indicated that such reporting requirements are consistent with the goals of Healthy People 2010 and recently enacted legislation directing the Secretary of Commerce to produce statistically reliable annual State data on the number of uninsured, low-income children categorized by race, ethnicity, age, and income. One commenter indicated that HCFA should require States to document the appropriate range of services and networks of providers available, given the various language groups represented by enrollees. Additionally, some commenters noted that HCFA should require States to provide an assessment of their compliance with civil rights requirements.

Response: We agree with several of the comments summarized above. Section 2107(b)(1) of the Act requires that ''a State child health plan shall include an assurance that the State will collect the data, maintain the records and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans.'' The proposed rule at § 457.740(a) had included requirements on States to collect and submit data by age categories, service delivery categories and by countable income. In an effort to streamline data reporting requirements, we had only encouraged States to collect data with respect to gender, race and ethnicity, and did not propose to require the collection or the reporting to HCFA of such data. We received many comments expressing concern about this policy and urging us to require States to report data on gender, race, ethnicity and primary language of SCHIP enrollees to HCFA.

We have reviewed our proposed policy and have decided that it is consistent with overall program goals, as well as the civil rights requirements, to require States to report data, on a quarterly basis, on the race, ethnicity, and gender of SCHIP enrollees using the format prescribed by the OMB Statistical Directive 15—Standards for the Maintaining, Collecting and Presenting Data on Race and Ethnicity. We have therefore amended § 457.740(a)(2) to reflect this requirement. Because primary language of SCHIP enrollees is not one of the data elements on standardized reporting formats, we will require States to report on this information as part of the Annual Report, and have amended § 457.750(b)(8) to reflect this change. We understand that nearly all States have already been collecting this information through the application process. Although States may request information on gender, race, ethnicity and primary language at the time of application, States may not require families to report this data as a condition of application to, or enrollment in the SCHIP program. The information must be collected from SCHIP applicants and enrollees on a voluntary basis. Having this data will enable States and the Department to see how and if minority children and other categories of children are being covered by the SCHIP program and to identify opportunities for more effective outreach and retention strategies.

Furthermore, required reporting of this data is consistent with Departmental priorities to more effectively identify racial disparities in the provision of health care and to assure that language barriers do not interfere with children's ability to secure health care. HCFA will modify its data base to permit States to report these data on the same system as they report enrollment data. We understand States may incur additional administrative costs to comply with this requirement. However, the potential benefits for the States and for the Department are significant.

Comment: Commenters asserted that neither the State nor the health insurance purchasing cooperative has the legal authority to require employer-sponsored insurance carriers to report claims data. Therefore, commenters noted, States with premium assistance programs would have difficulty reporting program expenditures and participants by age, income, delivery system, and program type as required by HCFA.

Response: Since States or their contractors would be completing the eligibility process for children enrolling through premium assistance programs, States would have data available on the child's age, family income, the type of child health insurance program offered by the State, and the expenditures being made on behalf of the child. We are not requesting individual claims data used by group health plans providing SCHIP

coverage. Service delivery systems could be ascertained by the State by reviewing the benefit package available through each employer. This might present difficulties if an employer had several options with varying delivery systems available at the same cost to the State. Should this be the case, we would work with States on a case-by-case basis to consider other options for collecting this data.

Comment: One commenter noted that the collection report Form HCFA–64, revised in December 1998, requires additional information that is not reflected in § 457.740, including number of months enrolled, and the number disenrolled per quarter. Several commenters suggested that HCFA require States to report this data to HCFA on a quarterly basis.

Response: In § 457.740, we did not intend to specify each data element that we will be requiring, because we wanted to be able to review and modify specific elements as the program evolves. We have authority under section 2107(b)(1) to specify at § 457.720, that States must provide data ''at the times and in the standardized format * * *'' to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI. This includes the number of months enrolled and number disenrolled per quarter.

The forms referenced by the commenter are quarterly reports used by State Medicaid agencies to report to HCFA their actual Medicaid expenditures and the numbers of SCHIP children and other children being served in the Medicaid program. HCFA uses these forms to ensure that the appropriate level of Federal payments for the State's Medicaid expansion program expenditures, and to track, monitor and evaluate the numbers of SCHIP children being served by the Medicaid expansion program. HCFA uses a similar quarterly reporting form, the HCFA–21, to collect comparable information on separate child health programs.

Comment: One commenter noted that the collection of data to measure the effectiveness of SCHIP should include the number and types of services actually delivered in addition to the number of children enrolled. This commenter suggested that we revise the regulations to specify that data can be collected and reported by the State using American Dental Association procedure codes to reflect total number of actual services rendered to eligible individuals.

Response: We agree States should consider utilization measures in developing Statewide performance measures of progress toward meeting State performance goals and strategic objectives. We also envision that States may want to measure care and service delivery so that they may determine numbers of participating providers and health networks needed for the program. The regulation provides States with flexibility in developing these measures and appropriate data collection methodologies.

As the Department works on developing and implementing a common core of standardized performance measures and performance goals, we will consider the outcome measures suggested by the commenter.

Comment: One commenter generally supported the quarterly reporting requirements but requested one additional required report measure. Specifically, the commenter urged HCFA to require reporting (either annually or quarterly) on the number of newborns who are enrolled at birth and the number of infants who are enrolled within the first three months of life. The commenter believed this information could be used by States to assess whether income-eligible newborns are experiencing gaps in coverage between the time of birth and SCHIP enrollment.

Response: We strongly encourage the States to collect the required information on age of participants in such a way that they may analyze the health coverage patterns of newborns and infants. We have not required States to report this information to HCFA. However, we will consider the commenter's suggestion as we develop the national core set of performance measures and goals.

Comment: One commenter urged HCFA to require States to describe their income calculation methodologies and changes in those methodologies and to make that information available to the public.

Response: We agree with the commenter's suggestion and note that income calculation methodologies and changes to these methodologies were requested to be provided by States as part of their State evaluations (due to HCFA on March 31, 2000). Because of the importance of having this information in a standardized manner, as well as keeping the information current, we have included this as an element of subsequent State annual reports. We have compiled and reviewed the submissions from the States thus far, and the information is available to the public along with the rest of the States' evaluations on the HCFA web site.

In addition, we discussed in our July 31, 2000 guidance on SCHIP section 1115 demonstrations that in order to receive approval for a demonstration proposal, States must have submitted all of their required statistical reports and evaluations to HCFA, dating back to the implementation of their program.

Comment: One commenter found the detailed reporting requirements problematic, cumbersome, and difficult to comply with under current automated systems.

Response: We recognize the commenter's concerns. However, we will continue to require the collection and quarterly reporting to HCFA of the data required in this section. We will continue to offer technical assistance to States having difficulty reporting the required data due to automated system difficulties. As noted previously, States are able to report data to HCFA through a web-based reporting system on the Internet, to provide States with easier access to the reporting system. In addition, we have developed a set of revised reporting instructions to facilitate reporting by States in a standardized format. We believe these modifications will result in a reporting system with which States can comply with minimal difficulties.

In addition, we are continuing a comprehensive evaluation of possible modifications to the Medicaid Statistical Information System (MSIS), which captures State eligibility and claims records on a quarterly basis. The modifications will give States the option of using MSIS to supply data related to separate child health programs as well as Medicaid expansion programs and will promote overall consistency among SCHIP and Medicaid data in the long term.

Comment: We received several comments applauding our recognition of the interrelationship of Medicaid and SCHIP and the requirement of similar reporting for regular Medicaid, Medicaid expansion, and separate child health programs. However, one commenter opposed the requirement that all States, including those operating separate child health insurance programs, report changes in enrollment in both the SCHIP program and the Medicaid program. The commenter noted that some States operate separate child health programs that are administered by different staff, governing boards, budgets, etc. than the State Medicaid program. The commenter opposed a requirement that a separately administered SCHIP program have a contractual requirement

to obtain data from a Medicaid agency. The commenter stated that if HCFA wished to review Medicaid data, it should develop new Medicaid regulations to require such data and to provide reimbursement to the Medicaid agency as the SCHIP program has no budget or legal authority to collect Medicaid data. The commenter added that additional administrative requirements from HCFA should be accompanied by additional administrative dollars, or they represent unfunded mandates that exacerbate the 10 percent administrative-cost limit problem.

Response: The statute anticipates that State agencies implementing SCHIP and Medicaid will coordinate activities and share information. Section 2108(b)(1)(C) of the Act requires States to report on or before March 31, 2000 ''an assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.'' In addition, section 2108(b)(1)(D) specifically requires States to report on coordination with other public and private programs providing health care and health financing, including Medicaid programs. Furthermore, these requirements are not specific to the State agency administering SCHIP or Medicaid, but rather apply to the State as a condition of receiving grant funding under these programs, regardless of how the State internally delegates responsibilities under these programs.

In addition, section 2107(b)(1) of the Act requires that the State plan contain certain assurances regarding the collection of data and submission of reports to the Secretary. In addition, § 431.16 of the Medicaid regulations specifies that a State plan must provide that the Medicaid agency will submit all reports required by the Secretary, follow the Secretary's instructions with regard to the format and content of those reports, and comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. These statutory and regulatory provisions serve as our authority for requiring Medicaid State expenditure and statistical reporting at § 457.740. State agencies can reasonably be expected, as directed in the statute, to coordinate among programs, including by sharing and reporting information.

Since Medicaid agencies receive Federal financial participation under title XIX for administrative costs, such as those associated with data collection, sharing this information with the States' title XXI programs should not exacerbate any difficulty States may have in staying within the 10 percent administrative cost limit in SCHIP.

6. Annual Report (§ 457.750)

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children. We proposed to implement the statutory provision requiring assessment of the program and submission of an annual report at § 457.750(a).

At proposed § 457.750(b), we set forth the required contents of the annual report. Specifically, in accordance with the statute, the annual report must provide an assessment of the operation of the State plan in the preceding Federal fiscal year including the progress made in reducing the number of uncovered, low-income children. In addition, we proposed to require that the State report on: (1) progress made in meeting other strategic objectives and performance goals identified by the State; (2) successes in program design and implementation of the State plan; and (3) barriers in program design and implementation and the approaches under consideration to overcome these barriers. We also proposed to require that the State report on the effectiveness of its policies for discouraging the substitution of public coverage for private coverage. Further, we proposed to require that the annual report discuss the State's progress in addressing any specific issues, such as outreach, that it agreed to monitor and assess in its State plan.

In accordance with section 2107(d) of the Act, we also proposed that a State must provide the current fiscal year budget update, including details on the planned use of funds for a three-year period and any changes in the sources of the non-Federal share of plan expenditures. We also proposed that the State must identify the total State expenditures for family coverage and total number of children and adults covered by family coverage during the preceding Federal fiscal year.

We proposed that, in order to report on the progress made in reducing the number of uncovered, low-income children in the annual report, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children who are uninsured in the State and provide annual estimates, using the chosen methodology, of the change in this number of low-income uninsured children at two poverty levels: 200 percent FPL and at the current upper eligibility level of the State's SCHIP program. We noted in the preamble to the proposed rule that, in making these estimates, a State would not be required to use the same methodology that it used in identifying the estimated number of SCHIP eligibles in the State plan.

We proposed to require that a State base the annual baseline estimates on data from either: (1) The March supplement to the Current Population Survey (CPS); (2) a State-specific survey; (3) other statistically adjusted CPS data; or (4) other appropriate data. We also proposed that a State must submit a description of the methodology used to develop these estimates and the rationale for its use, including the specific strengths and weaknesses of the methodology, unless the State bases the estimate on the March supplement to the CPS. We indicated in the preamble to the proposed rule that, once a State submits a specific methodology in the annual report for estimating the baseline numbers, the State must use the same methodology to provide annual estimates unless it provides a detailed justification for adopting a different methodology. We also noted therein that traditionally, most national estimates of uninsured children have been based on the Bureau of Census March Current Population Survey (CPS). We further noted in the preamble that, as the only data source with the capacity to generate State-by-State estimates of uninsured children, the CPS generally is relied upon by policy makers to provide an overall estimate of insurance status and insurance trends in the nation. We also mentioned other major surveys that provide insight into the number of uninsured Americans.

Comment: One commenter recommended that we require annual reports to contain reasonable utilization measures indicating quality and access to care for children with special needs in addition to the general child population. The commenter believed that the Secretary should conduct a focused study of children with special needs. Another commenter noted that States providing dental benefits should report annually on the assistance provided to recipients in accessing needed services.

Response: We are very concerned about services for special needs children, and we agree with the commenters that quality and access are important both with respect to special needs and dental benefits and States are encouraged to address these important

areas in their annual reports. However, requiring such reporting would be inconsistent with the flexibility permitted under the statute. At § 457.495(b) of this final rule, we require States to provide assurances of appropriate and timely procedures to monitor and treat enrollees with chronic, complex or serious medical conditions, including access to specialists experienced in treating the specific medical condition. We leave it to the States to determine what systems and procedures they will implement to ensure enrollees with such conditions have access to quality care consistent with this standard.

In order for States to create systems which fit their unique programs, the methodology for complying with § 457.495 is best left to the State. Reporting on access to dental benefits is subsumed under § 457.495(a), which requires States to include in their plans a description for assuring the quality and appropriateness of care provided under the plan including access to covered services listed in § 457.402(a). Dental services is one of the optional services States may cover under the definition of child health assistance located at § 457.402(a)(16). To the extent that States cover dental services in their SCHIP plans, they must assure access to those services. Therefore, we have not adopted the commenter's suggestion to add a separate requirement regarding dental services.

Comment: One commenter asserted that HCFA exceeds its authority in the annual report requirements at § 457.750(c) that requires States to provide a rationale and description of the methodology used to establish the baseline estimate, if the estimate is based on a source other than the CPS. The commenter contended that the purpose of the annual report is for States to assess the operation of their programs. The commenter also argued that HCFA lacked authority to compel States to adopt the CPS standard. The commenter referred to section 2108 of the Act, which provides that the State shall assess its performance and submit that assessment to the Secretary. The commenter noted that providing a rationale for a methodology made States take additional steps that were not prescribed by the statute. In requiring this rationale, the commenter suggested HCFA came perilously close to dictating the CPS standard, which violates the express terms of title XXI and Executive Order 13132, regarding Federalism. The commenter indicated that under Executive Order 13132, HCFA is required to justify the imposition of any national standard and to look for less burdensome alternatives. The commenter expressed the view that the proposed rule improperly shifts the burden of justifying standards used to evaluate programs from HCFA to the States.

Response: Section 2107(b)(1) of the Act expressly gives the Secretary the authority to require data collection, records maintenance, and reports from the States ''at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and to evaluate and compare the effectiveness of State plans.'' In order to effectively monitor State program effectiveness in reducing the number of uninsured children, the method of detecting the numbers of uninsured in States and the decline or increase in the uninsured must be known and understood in a standardized manner when possible. The statute uses CPS for formula allocating, so it was suggested as the best available source for State uninsurance levels among low-income children. Most States elected to use the CPS in establishing their initial baselines. However, we recognize the shortcomings of CPS for many States and have therefore provided flexibility to use other sources, both initially and prospectively. The requirement that States explain their alternative methodology is necessary and appropriate in order for HCFA to be able to identify and assess the data provided by States. In addition, we have further clarified that if States elect to use a different data source in re-establishing a baseline, the State must also note in the annual report the CPS estimate for that year, both as a means of providing standardized information across States, using a consistent baseline and to ensure that States are given credit for progress in enrolling children back to the beginning of their programs.

Comment: One commenter requested that HCFA allow States to use biennial State survey figures in assessing changes in uninsurance rather than the annual figures from the CPS. The commenter noted that the CPS data is unreliable for its State and administering an annual survey would be cost-prohibitive for some States.

Response: Section 457.750(c)(1)(ii) provides that a State may base its estimate of the number of uninsured, low-income children from a State-specific survey. Thus, States may use biennial data from State surveys, utilizing statistically relevant adjustments in the off-survey year or by supplementing the biennial data with additional State-specific data from other sources to fulfill the annual reporting requirements of this section. We note that, as stated in the previous response, States will be required to provide a description of the methodology and rationale for using the State-specific survey, in accordance with § 457.750(c)(2).

Comment: One commenter urged HCFA to revise the proposed rule to reflect provisions of the Balanced Budget Refinement Act of 1999 (BBRA), which require that the March Supplement of the CPS be expanded to allow State-level estimates of the number of uninsured children. The commenter believed that using these updated estimates would be preferable to allowing States to establish their own methodologies for estimating the number of uninsured children.

Response: We note that provisions of section 703(b) of BBRA amended Section 2109 of the Act to modify the March Supplement of the CPS to detect real changes in uninsurance rates of children. The BBRA requires future modifications to the Current Population Survey in order to produce statistically reliable annual State-level data on the number of low-income children without health insurance coverage. One modification to the CPS is to include data on children by family income, age, and race, and ethnicity. Adjustments to be made include expanding sampling size used in State sampling units and expanding the number of sampling units in a State. Therefore, with the creation of this requirement, Congress sought to help provide all States with access to more reliable State-level data on the uninsured population through the CPS March Supplement. We have not modified the regulation text to reflect this change, as this data is not expected to be available until October or November 2001. We wanted to leave the regulation text open to future improvements to the CPS or other data sources. Even with the CPS adjustments, there are States that believe they can provide more accurate estimates of the level of uninsured children in their State with methodologies that use other data sources or sources that supplement the CPS data. We believe it is important to allow States this flexibility in developing the most reliable estimate for their State.

Comment: One commenter supported the required collection of information in the annual report, and recommended we require States to also report on the following information in the annual reports:

—Progress in addressing the barriers to access experienced by minority children;

—Grievances, complaints of problems reported relating to enrollment, access, and quality of care as a means of measuring consumer satisfaction, ensuring they are adequate to resolve complaints within a reasonable time frame and that plans use grievance and complaint data to improve quality;
—Cultural competency measures;
—Continuity of care between plans, providers, or programs;
—Special attention to under-served or under-identified populations (for example, homeless children);
—Systematic integration with schools and other community groups;
—Whether primary care and pediatric specialty care capacity is adequate for the number of enrollees;
—Whether plans meet standards for access within reasonable time frames;
—Whether care is in accordance with clinical practice guidelines for quality of care; and
—The proportion of providers who are both Medicaid and separate SCHIP providers among those serving Medicaid and separate SCHIP beneficiaries, and the difference in payment rates to plans or providers in Medicaid and separate SCHIP programs.
—Estimates of the number of uninsured children under the regular Medicaid income thresholds as well as those under the 200 percent FPL and under the State's SCHIP income threshold;
—Data on the method of application for Medicaid and SCHIP (mail-in, outstation-site, Internet, etc.) and enrollment procedures for each program;
—Data on the portion of applicants denied and reason for denial;
—Number of children disenrolled for any reason, the reason for disenrollment, and the number of children disenrolled for nonpayment of premiums;
—Number of children continuously enrolled in Medicaid and/or separate SCHIP program for one year or more;
—Number of children identified by screening as Medicaid eligible and, of those, the number enrolled in Medicaid;
—Number of former Medicaid recipients enrolled in separate SCHIP;
—Data on the number of applicants denied eligibility and the reason for the denial, including that they were disqualified due to current insurance coverage as well as the number of children disqualified due to insurance coverage in a past period, where applicable;
—Number of children who lose coverage at redetermination and the reason for loss of coverage; and
—Data comparing the proportion of children enrolled and using services by gender, race, ethnicity, and primary language to the proportion of such children in the service area.

Response: As noted earlier, HCFA participated in a workgroup led by the National Academy of State Health Policy to develop a template for States' annual reports that have provided an opportunity for States to report the information required in § 457.750 in a standardized way. NASHP released this template to the States and the public in November 2000 for States to use in completing their annual reports for FY 2000. In addition to budget and expenditure data, this will include information from States on their progress in reducing the number of uninsured low-income children, meeting strategic goals and performance measures, the effectiveness of States' policies for preventing substitution of coverage, and identifying successes and barriers in the States' plan design. In addition, the reports provide a forum for evaluating States' progress in addressing specific issues (such as outreach) and the primary language of SCHIP enrollees. We will work with NASHP to include these elements in a revised version of the annual report framework upon publication of this final rule. States will not be expected to address these new elements until they submit their FY 2001 reports. In addition, because the information can be more appropriately displayed in the annual report than in the quarterly reports, we have added a new § 457.750(b)(7) to require States to provide information on primary language of SCHIP enrollees in their annual reports. HCFA will continue to closely review the data collected and reported by the States in their annual reports.

We note that many of these assessment elements were provided by States in their State evaluations. Specifically, as part of the evaluation, States were required, as specified in section 2108(b)(1) of the Act and laid out in the NASHP evaluation framework, to provide information on baseline numbers of uninsured low-income children in the State by income level; levels of previous insurance coverage for applicants and enrollees; and quarterly enrollment statistics including: number of children ever enrolled; new enrollment; number of member months enrolled; average months enrolled; disenrollment including the reasons for disenrollment; unduplicated count of enrollment; and enrollee characteristics, such as income. Many States provided additional information on enrollees' gender, race and ethnicity in the reports. The annual report template is not as extensive as the evaluation template, but many of the same elements are included. Therefore, States will have the ability to indicate in subsequent annual reports that no update is needed since the evaluations were submitted.

Finally, it should be noted that, as we work toward developing and implementing a national core set of performance measures and goals, we will consider the performance goals suggested by the commenters.

Comment: One commenter noted that the preamble to proposed § 457.750(c)(1) was unclear as to whether the program referred to in the phrase ''upper eligibility level of the State's program'' is Medicaid or SCHIP.

Response: The requirements of subpart G of the regulations regarding strategic planning, reporting, and evaluation apply to separate child health programs and Medicaid expansion programs. Thus, in § 457.750(c)(1), we are referring to the upper eligibility level of the State's SCHIP program, which would be the upper eligibility level of either a Medicaid expansion or a separate child health program. If a State operates a combination program, the upper eligibility level would be the highest eligibility level of either the Medicaid expansion or the separate program.

Comment: One commenter recommended that specific measures be defined either for all SCHIP programs or separately for employer-sponsored insurance model programs based on HEDIS or Healthy People 2000 guidelines, to ensure that all States report similar guidelines and that common agreements could be used across States. Given that some States plan to use an employer-sponsored insurance model for coverage, the commenter suggested that HEDIS measures would seem the most appropriate approach on which to base data collection and reporting systems. For States using an employer-sponsored insurance model, contracts or agreements between the State and carriers would be needed for collection and data provision, this commenter stated. In this commenter's view, States would have to create specific data collection and reporting mechanisms to do this.

Response: The regulations do not require States, including States with premium assistance programs, to collect data on specifically defined measures, except with respect to any core set of performance measures that may be developed by the Secretary at a later

date. We encourage States to work with health plans, HCFA, and each other to create standards that meet their mutual needs for data. We particularly encourage States using premium assistance program models for SCHIP to explore effective methods of data collection, but recognize that data collection will present particular challenges to these types of programs because the State may not have direct contractual relationships with employer group health plans or with health insurance issuers offering group health insurance coverage. States may need to explore alternative methods of data collection for premium assistance programs, such as consumer surveys and polling.

Comment: One commenter expressed concern that the requirement at § 457.750(b)(5) stating that the annual report must include an updated budget is unnecessary and duplicative of other ongoing requirements, including the HCFA form 37, ''Medicaid Program Budget Report—State Estimate of Quarterly Grant Award.''

Response: The requirement for updated budgets in the annual report is necessary for the sound administration of SCHIP. Annual reporting of updated budgeting with three-year projections, including changes in sources of non-Federal funding and details on the planned uses of all funds, is essential to sound financial management of this program. Annual updated reports are also essential to HCFA as it monitors and anticipates the financial needs of States implementing SCHIP programs. Because States have up to three years to spend each annual allotment, a three-year budget is useful to show if States are planning to use their unused allotments in the succeeding two fiscal years or if they anticipate a shortfall in Federal funding. Therefore, we have decided to retain this requirement for a three-year budget in the final regulation. However, we are no longer requiring a three-year budget with all amendments. Instead, we have limited the requirements at § 457.80 to a one-year budget only with amendments that have a significant budgetary impact. A more detailed discussion of this issue can be found in the comments and responses to § 457.80.

Comment: One commenter noted that in § 457.750(b)(5) of the proposed rule, States are required to include in the annual report an updated budget for the current Federal fiscal year. The commenter states that HCFA did not take into account the State appropriations process and the fiscal year used by the State as opposed to the Federal fiscal year. For example, Illinois has a July-June fiscal year, with the legislature appropriating funds for the final Federal quarter (July-September) in May. Therefore, the commenter noted, the last quarter in the SCHIP annual report will be an estimate. The commenter believed that the regulations regarding the annual report should be revised to permit States to estimate budgets for the final Federal quarter.

Response: We have modified § 457.750(b)(5) as proposed. Instead of requiring an annual budget for the current fiscal year, we now require an annual updated budget for a three-year period. We realize that the three-year budgets States are required to submit annually in fulfilling the requirements of § 457.750(b)(5) are based on projections and may vary from actual expenditures for a variety of reasons. However, we believe it is important to have this information to ensure that States have adequately planned for the program and to analyze spending allotments.

7. State Evaluations (§ 457.760)

In proposed § 457.760 we set forth the requirement that States submit a comprehensive evaluation by March 31, 2000 that analyzes the progress and effectiveness of the State child health program. In the evaluation, a State must report on the operation of its Medicaid expansion program, separate child health program, or combination program. As specified in section 2108(b)(1)(B) of the Act, the State evaluation must include all of the following:

- An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage. In addition, the State must report on progress made in meeting other strategic objectives and performance goals identified by the State plan.
- An assessment of the State's progress in meeting other strategic objectives and performance goals identified by the State plan.
- A description and analysis of the effectiveness of elements of the State plan, including the following elements:
  - —The characteristics of the children and families assisted under the State plan, including age of the children and family income. The State also must report on children's access to, or coverage by, other health insurance prior to the existence of the State program and after eligibility for the State program ends (the child is disenrolled). As an optional strategy, the State also should consider reporting on other relevant characteristics of children and their families such as sex, ethnicity, race, primary language, parental marital status, and family employment status.
  - —The quality of health coverage provided under the State process or other process that is used to assure the quality and appropriateness of care.
  - —The amount and level of assistance including payment of part or all of any premiums, copayments, or enrollment fees provided by the State.
  - —The service area of the State plan (for example, Metropolitan Statistical Area (MSA) or non-MSA).
  - —The time limits for coverage of a child under the State plan. As an optional strategy, the State should consider reporting the average length of time children are assisted under the State plan.
  - —The extent of substitution of public coverage for private coverage and the State's effectiveness in designing policies that discourage substitution.
  - —The State's choice of health benefits coverage, including types of benefits provided and the scope and range of these benefits, and other methods used for providing child health assistance.
  - —The sources of non-Federal funding used in the State plan.
- An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.
- A review and assessment of State activities to coordinate the SCHIP plan with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.
- A description of any plans the State has for improving the availability of health insurance and health care for children.
- Recommendations for improving the SCHIP program.

Comment: One commenter indicated that the State evaluation requirements should be less prescriptive and require an analysis of the effectiveness of elements the State may include rather than requiring an analysis of all eight elements listed at § 457.760(c). The commenter asserted that such policy would allow States to identify and address areas relevant to their own State plans. The commenter suggested that we revise this section to provide that ''a description and analysis of elements of the State plan *may* include:'' the elements in paragraph (c) of this section.

Response: States were statutorily required to report on the progress of the elements set forth in § 457.760(c) in the State evaluation, due to HCFA on March 31, 2000, and we modeled the proposed regulation text after the statute. Section 2108(b) of the Act specifies the contents of the State evaluation. HCFA therefore does not have discretion to make these requirements optional for States. In addition, because all the States have submitted the required evaluation, we have removed this provision from the final rule. Any request for future evaluations will be based upon the requirements in the statute for evaluations and annual reports on the program.

Comment: We received several comments expressing appreciation that the guidance set forth in the preamble to the proposed rule regarding the evaluation closely followed the evaluation framework developed by NASHP and the State workgroup. However, several commenters asserted that the information provided in State evaluations should not be used to establish model programs and practices. Rather, they noted, States should be given the freedom to design programs that best suit the needs of their population and circumstances, and information provided in the evaluation should focus on how the States have used the flexibility allowed by the program to create unique and successful plans.

Response: We are using the evaluations to identify model practices. We believe that the identification of model practices should not involve comparing unlike programs or overlooking the unique circumstances of each State. Many States have been eager to learn about other State practices. We envision model practices as a means of sharing information with States and other interested parties on how other States have successfully implemented certain parts of their program. We develop model practices not as a means of judging or evaluating programs, but rather as a means of sharing those practices that have proven successful for one State so that other States may determine the merit of adopting similar practices in their own SCHIP implementation.

Comment: One commenter recommended that we require States to report on the provision of services as well as the participation rates of pediatricians and other child health care providers in the program. Additionally, the commenter recommended that we require States to report the average cost-sharing requirements for families who choose to enroll in SCHIP rather than employer-provided coverage. The commenter believed that we should also require States to include an evaluation of the impact States' efforts to minimize substitution have had on children with special health care needs and their access to services. The commenter believed that HCFA should also require States to include evaluations of their screen and enroll processes.

Response: We do not agree with the commenter's suggestion. The evaluation template developed by the National Academy for State Health Policy reflects those elements specified in section 2108(b)(1)(B) of the Act. To this extent, it did include assessment questions on the State's cost sharing and its effects on participants as well as questions regarding the State's screen and enroll process and its substitution policies and results of monitoring rates of substitution. We have further included a provision at § 457.353 that specifically requires States to monitor and evaluate the effectiveness of the screening process. The regulatory requirements are consistent with the statute. In some cases, States included additional data or other information such as the data suggested by the commenter, in their SCHIP evaluations as additional measures of their progress toward strategic objectives of that State.

Comment: One commenter supported the proposed categories of evaluation, but requesting that we require more frequent reporting and evaluation.

Response: Section 2108(b) of the Act, as implemented in § 457.760, required States to submit evaluations by March 31, 2000. We believe the information States will be providing through the quarterly and annual reports required by § 457.740 and § 457.750 respectively, will be sufficient to allow ongoing assessments of States' SCHIP programs, making more frequent reporting and formal evaluations unnecessary and overly burdensome on States. The statute did not include a subsequent requirement for an annual evaluation and we have, therefore, removed this provision from the final rule.

Comment: One commenter recommended that HCFA clarify § 457.750(c)(1) by replacing the phrase ''coverage by other health insurance prior to the State plan'' with ''coverage by other health insurance prior to coverage under the State plan.''

Response: Because we have deleted this provision from the final rule, we have not adopted the commenter's suggestion.

Comment: One commenter recommended that HCFA encourage States to build on existing data collection efforts and systems, including State title V efforts, in developing overall SCHIP evaluation efforts and in collection of data.

Response: We encourage States to build on existing databases and title V efforts, as well as public-private partnerships in order to facilitate the development and implementation of information tracking systems and SCHIP program evaluation efforts.

G. Subpart H—Substitution of Coverage

1. Basis, Scope, and Applicability (§ 457.800)

Title XXI requires that States ensure that coverage provided under SCHIP does not substitute for coverage under either private group health plans or Medicaid. Section 2102(b)(3)(C) of the Act requires that State plans include descriptions of procedures used to ensure that the insurance provided under the State child health plan does not substitute for coverage under group health plans. Another provision in title XXI relating to substitution of coverage is section 2105(c)(3)(B), which sets out the conditions for a waiver for the purchase of family coverage as described in § 457.1010. Under this provision, States must establish that family coverage would not be provided if it would substitute for other health insurance provided to children.

In addition, title XXI contains several provisions aimed at preventing SCHIP from substituting for current Medicaid coverage. First, sections 2102(a)(2) and 2102(c)(2) of the Act requires States to describe procedures used to coordinate their SCHIP programs with other public and private programs. Second, section 2105(d) of the Act includes ''maintenance of effort'' provisions for Medicaid eligibility. That is, under section 2105(d) of the Act, a State that chooses to create a separate child health program cannot adopt income and resource methodologies for Medicaid children that are more restrictive than those in effect on June 1, 1997. Furthermore, section 1905(u)(2)(b) of the Act also provides that a State that chooses to create a Medicaid expansion program is not eligible for enhanced matching for a separate coverage provided to children who would have been eligible for Medicaid in the State under the Medicaid standards in effect on March 31, 1997. Finally, section 2102(b)(3)(B) of the Act requires that any child who applies for a separate child health program must be screened for Medicaid eligibility and, if found eligible, enrolled in Medicaid.

This subpart interprets and implements section 2102(b)(3)(C) of the Act regarding substitution of coverage

under group health plans and sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs. These requirements apply only to separate child health programs.

Comment: Many commenters questioned the magnitude of the risk for substitution of private group health plan coverage by SCHIP coverage for children. Because the size of the risk of substitution by SCHIP coverage offered under both employer-sponsored insurance programs and non-employer-sponsored insurance programs is unclear, and because of the harm that substitution prevention policies may inflict, the commenters encouraged HCFA not to put forth a policy to prevent substitution that goes beyond what is clearly required by the statute. Many commenters also recommended that we revisit our policy on substitution because of their concern that waiting periods and other substitution prevention policies are causing significant harm to families with children with special health care needs and argued that such families can ill afford to go without coverage for any period of time.

Response: We have revisited our policy on substitution and made several changes. With respect to substitution policies outside of the context of premium assistance programs, we note that the proposed regulatory text at § 457.805 requires only that the State plan include reasonable procedures to prevent substitution. This approach permits State flexibility and implementation of policies based on the emerging research regarding substitution and on State experiences with substitution.

Our review of States' March 31, 2000 evaluations indicated that in those States with data on substitution of private coverage with SCHIP coverage, there was little evidence that substitution was as great an issue as initially anticipated.

Thus, we have revised the policy stated in the preamble to the NPRM regarding substitution procedures relating to SCHIP coverage provided outside of programs that offer premium assistance for coverage under group health plans as follows: States that provide coverage to children in families with incomes at or below 200 percent of FPL must have procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage, as was the policy for such coverage provided to families under 150 percent of FPL proposed in the preamble to the NPRM.

States that provide coverage to children in families with incomes over 200 percent of FPL should, at a minimum, have procedures to evaluate the incidence of substitution of SCHIP coverage for existing private group health coverage. In addition, States offering coverage to children in families over 200 percent of FPL must identify in their State plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution. States must determine a specific trigger point at which a substitution prevention mechanism would be instituted, as described in the State plan. For coverage above 250 percent of the FPL, because evidence shows that there is a greater likelihood of substitution at higher income levels, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States may submit amendments to their State plans if they would like to modify their current policies in light of the policies discussed here. We plan to work closely with each State to develop appropriate substitution strategies, monitoring tools, and trigger mechanisms.

For premium assistance programs, we have revised our substitution policy in this final rule in two areas. We have eliminated the requirement for a 60 percent minimum employer contribution. We will no longer mandate a specific level of contribution, since a substantial employer contribution must be made in order for coverage subsidized through employer plans to be cost-effective, as required under § 457.810. States will be expected to identify a reasonable minimum employer contribution level and provide justification for that level, including data and other supporting evidence, that will be reviewed in the context of the State plan amendment process. In addition, as proposed in the NPRM, States with premium assistance programs must monitor employer contribution levels over time to determine whether substitution is occurring and report their findings in their State annual reports.

The identification of the minimum employer contribution and the monitoring process will help ensure that SCHIP funds are being used to supplement the cost of employer-sponsored insurance, not supplant the employers' share of the cost of coverage. While these revisions are intended to provide additional State flexibility to develop premium assistance programs and provide coverage to families, it is important to note that the cost-effectiveness test established by title XXI and set forth in § 457.810 must be met in all cases.

The second change we are making relates to the required waiting period of uninsurance. We have retained the requirement for a minimum 6-month period without group health coverage, but will permit exceptions to the waiting period, as discussed in more detail in the comments and responses to section § 457.810.

2. State Plan Requirements: Private Coverage Substitution (§ 457.805)

The potential for substitution of SCHIP coverage for private group health plan coverage exists because SCHIP coverage may cost less or provide better coverage than coverage some individuals and employers purchase with their own funds. Specifically, employers who make contributions to coverage for dependents of lower-wage employees could potentially save money if they reduced or eliminated their contributions for such coverage and encouraged their employees to enroll their children in SCHIP. At the same time, families that make significant contributions towards dependent group health plan coverage could have an incentive to drop that coverage and enroll their children in SCHIP if the benefits would be comparable, or better, and their out-of-pocket costs would be reduced.

In accordance with section 2102(b)(3)(C) of the Act, we proposed at § 457.805 to require that each State plan include a description of reasonable procedures that the State will use to ensure that coverage under the State plan does not substitute for coverage under group health plans.

We opted not to propose specific procedures to limit substitution. Instead, we discussed in detail reasonable procedures that States may use to prevent substitution of coverage. Specifically, we stated in the preamble to the NPRM that we would consider the following to be reasonable procedures for addressing the potential for substitution:

- States that provide coverage to children in families at or below 150 percent of the Federal poverty line (FPL) should, at a minimum, have procedures to monitor the extent of substitution of that coverage for existing private group health coverage.
- States that provide coverage to children in families between 150 and

200 percent of FPL should, at a minimum, have procedures to study the incidence of substitution of that coverage for existing private group health coverage. In addition, States should specify in their State plans the steps they will take to prevent substitution in the event that the States' monitoring efforts discover substitution has occurred at an unacceptable level.

• States that provide coverage to children in families above 200% of FPL should implement, concurrent with program implementation, specific procedures or a strategy to limit substitution.

We noted that we would ask States to assess the procedures to limit substitution in their evaluations submitted in March of 2000. We also asked all States that specified in their plans that they would monitor substitution to submit information on substitution in their annual reports.

We also addressed the issue of applying substitution provisions to the Medicaid eligibility group for the ''optional targeted low-income children'', which was added to section 1902(a)(10)(A)(ii)(XIV) of the Act pursuant to section 4911 of the BBA. In the NPRM we clarified that States may not apply eligibility-related substitution provisions, such as periods of uninsurance, to the ''optional targeted low-income children'' group, because such eligibility conditions are inconsistent with the entitlement nature of Medicaid. We have retained this policy in this final regulation. States that currently apply eligibility-related substitution provisions to optional targeted low-income children will need to come into compliance with this clarified policy. States that have not already come into conformity with this policy will have 90 days from the date of this notice to do so and must submit a State plan amendment in compliance with § 457.65(a)(2). We recognize that States expanding Medicaid to optional targeted low-income children at higher income levels may be particularly concerned about the potential for substitution of coverage. States that want to maintain waiting periods for the optional targeted low-income children group may want to submit section 1115 demonstration requests for approval of substitution provisions. HCFA will consider section 1115 demonstration requests on a case-by-case basis.

Comment: Although neither the preamble nor the proposed regulatory text explicitly prescribed a mandatory waiting period or period without group health insurance, as a condition of eligibility in separate child health programs that are not providing premium assistance for group health plans, many commenters expressed their dislike for the Department's policy implemented in the course of approving State plans and plan amendments, of mandating the imposition of periods without insurance for populations over 200 percent of the FPL.

Many commenters indicated that waiting periods are unnecessary in general because they block access to care without any proof of their effectiveness in preventing substitution. Some commenters stated that the data on the significance of substitution has been inconclusive. One commenter referred to recent data from the Current Population Survey (CPS) on trends in coverage for low-income children that, in their view, raised serious questions about the magnitude of any crowd out effect of expansions in publicly-funded coverage for children. Another concern raised was that waiting periods without insurance impose a significant hardship for families who may be struggling to keep up premium payments, obtain care for children with special health care needs, or get by with inadequate private coverage for their children.

Response: Our review of States' March 31, 2000 evaluations indicated that in those States with data on substitution of private coverage with SCHIP coverage, there was little evidence that substitution was as great an issue as initially anticipated. However, because of the current lack of conclusive data around the level of substitution which may be occurring below 200 percent of FPL, we maintain that monitoring of substitution of coverage in SCHIP is critical.

As noted above, we have revised the policy stated in the preamble to the NPRM regarding substitution procedures relating to SCHIP coverage provided outside of programs that offer premium assistance for coverage under group health plans as follows:

• States that provide coverage to children in families at or below 200 percent of FPL must have procedures to monitor the extent of substitution of SCHIP coverage for existing private group health coverage, as was the policy for such coverage provided to families under 150 percent of FPL proposed in the preamble to the NPRM.

• At a minimum, States that provide coverage to children in families with incomes over 200 percent of FPL should have procedures to evaluate the incidence of substitution of SCHIP coverage for existing private group health coverage. In addition, States offering coverage to children in families over 200 percent of FPL must identify in their State plans specific strategies to limit substitution if monitoring efforts show unacceptable levels of substitution. States must monitor the occurrence of substitution and determine a specific trigger point at which a substitution prevention mechanism would be instituted, as described in the State plan.

• For coverage above 250 percent of the FPL, because evidence shows that there is a greater likelihood of substitution at higher income levels, States must have substitution prevention strategies in place, in addition to monitoring.

Although a period of uninsurance is one possible substitution prevention procedure, we invite States to propose other effective strategies to limit substitution. States may submit amendments to their State plans if they would like to modify their current policies in light of the policies discussed here. We plan to work closely with States to develop appropriate substitution strategies, monitoring tools, and trigger mechanisms. As part of monitoring for substitution of coverage, States should also study the extent to which anti-substitution policies require children who have lost group health coverage through no fault of their own or their employer to wait to be enrolled in SCHIP. To the extent that monitoring finds that such children are forced to go without coverage, States should consider adjustments to their substitution prevention policies that permit exceptions for children who should not be the target of such policies. We will continue to ask States to assess their substitution prevention procedures in their annual reports.

Finally, we note that because the regulatory text at § 457.805 required that the State plan include reasonable procedures to prevent substitution and made no distinction for eligibility levels for coverage under State plans, we have not revised the regulation text. It is consistent with our revised policy.

Comment: Several commenters believed that States should be allowed to establish guidelines that would allow families to drop coverage without penalty of a SCHIP-required waiting period and to enroll the child or children in the State's SCHIP program if they are paying more than they can afford for the child's insurance. The commenters indicated that, in some cases, the child may have special health needs and/or the family may be paying for insurance that does not cover many of the child's needs but serves only as insurance against a catastrophic event. In addition, some commenters suggested that States not be allowed to impose periods of uninsurance that impede the

delivery of preventive care and immunizations consistent with the AAP Guidelines for Health Supervision III and Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents.

Response: As stated above, periods of uninsurance will not be required unless coverage is provided via premium assistance through group health plans, coverage is provided to children with significantly higher income levels, or substitution has been identified as a problem in the State. Furthermore, in the case of States with premium assistance programs, we continue to permit States to cover such children under a separate child health program (outside of coverage through premium assistance programs) during the waiting period, as stated in the preamble to the proposed rule. The required period of uninsurance applies only to SCHIP coverage provided through group health plans.

States are therefore able to enroll special needs children, and those in need of preventive care and immunizations, in SCHIP in a timely fashion so as not to disrupt the provision of needed health care services. To the extent a State chooses to adopt periods of uninsurance, the State may want to consider exceptions to the period of uninsurance to address issues raised by the commenters. We note, however, that access to immunizations is unlikely to be proposed as an exception since virtually all younger children would thereby be exempt.

Comment: One commenter urged the Department to view State substitution prevention efforts as a comprehensive plan, rather than isolating specific pieces that may or may not measure up to artificial Federal guidelines. In addition, the commenter noted that each State has developed a substitution prevention strategy that is applicable to the demographic and economic situation in the State, and State plans should therefore be judged in their entirety, not in a piecemeal fashion.

Response: We agree that State's substitution prevention efforts should be considered in the context of the entire State plan with consideration given to a State's particular needs and goals. To this end, we have retained a flexible regulatory requirement regarding substitution and indicated that HCFA will incorporate additional flexibility in its plan review process.

Comment: One commenter agreed with the language in proposed § 457.805 and suggests that HCFA limit States' discretion to use fears about substitution as an excuse to deny health coverage and recommended that final regulations bar waiting periods (outside of the premium assistance arena) that either: (1) Impose harm on children by going beyond 6 months or deny coverage (except where the employee voluntarily drops employment-based coverage without any change in circumstances) for pregnant women, children with disabilities, or children with preexisting conditions as defined by HIPAA; or (2) deny SCHIP benefits to children without employer-sponsored insurance for reasons unrelated to SCHIP (recent adoption, loss of job, end of COBRA coverage, death of a parent, moving outside the plan's service area, or an increase in premiums that was unaffordable to the family).

Response: As indicated above, outside of premium assistance programs, States have broad discretion to develop substitution prevention policies that best serve their particular populations. States that choose to retain or impose periods of uninsurance are encouraged to include exceptions that help prevent the imposition of undue hardship under a range of circumstances, including loss of insurance through no fault of the family, extreme economic hardship, death of a parent, etc.

Comment: One commenter indicated that, while in agreement that our proposed policy on substitution for the lower income population is reasonable, HCFA should carefully monitor State programs for children under 200% FPL to assure that no substitution problems emerge.

Response: We will continue to review State plan amendments to ensure that States monitor the occurrence of substitution at all income levels, and to review annual reports for any reported experiences of substitution. As stated in previous guidance from HCFA, in the event monitoring efforts indicate unacceptable levels of substitution, HCFA may reconsider the requirements intended to prevent substitution of coverage.

Comment: One commenter indicated confusion about the preamble language which ''does not require'' the use of eligibility-related substitution prevention provisions such as periods of uninsurance for the Medicaid eligibility group for the ''optional targeted low income children,'' but goes on to say that States that currently apply eligibility-related substitution prevention provisions to optional targeted low-income children ''will need to come into compliance with this proposed policy.'' The commenter believed our language should have indicated we would ''not allow'' such States to impose a waiting period as opposed to ''not require.''

Response: The commenter is correct. The policy is that the Medicaid statute does *not allow* the use of eligibility-related substitution prevention provisions such as periods without insurance for ''optional targeted low income children'' (outside of demonstration projects under the authority of section 1115 of the Act).

Comment: One commenter asked for clarification whether the proposed requirements with respect to substitution at § 457.800(c) applied only to separate child health programs and not to Medicaid expansion programs.

Response: As noted by the commenter, this point needs clarification. This subpart, as stated at § 457.800(c), applies only to separate child health programs. We have removed the reference to subpart H at § 457.70, which had indicated the requirements that apply to Medicaid expansion programs.

Comment: Several commenters indicated support for the clarification that waiting periods are not allowed in Medicaid expansions (outside of section 1115 demonstrations). One commenter asserted that this is consistent with Congressional intent that all Medicaid rules should apply to title XXI expansions of Medicaid. Another commenter suggested using caution when granting 1115 demonstrations to implement substitution prevention provisions when expanding Medicaid eligibility.

Response: We agree with the first two points and note the concerns raised in connection with section 1115 demonstrations.

Comment: One commenter indicated that States should be permitted the flexibility to implement the substitution provisions that they determine are necessary for their own SCHIP programs, and that this should be the rule whether the program is a Medicaid expansion or a separate program. Another commenter believed that it is unfair not to require a six-month waiting period for Medicaid expansion programs because it presents an unfair barrier to separate child health programs.

Response: The final rule allows States the flexibility to identify and implement substitution prevention provisions that are necessary for their own separate child health programs, within the parameters discussed above. Title XXI explicitly requires States to have substitution policies. By contrast, waiting periods are not permitted in Medicaid expansion programs outside of section 1115 demonstrations.

Comment: One commenter stated that HCFA should consider whether the imposition of substitution provisions, such as mandated periods of uninsurance applied to adults under family coverage waivers, would have an undesirable effect on the children's access to services.

Response: We agree that waiting periods may have an adverse impact on children's access to care. In this final rule, HCFA is requiring States to monitor the extent to which substitution prevention policies require children who have lost group health coverage, through no fault of their own or on the part of their employer, to wait to be enrolled in SCHIP. If monitoring shows that such children are forced to go without coverage, States should consider adjustments to their substitution prevention policies that permit exceptions for children who should not be the target of such policies. Because research shows that the risk of substitution is greater when a State operates a premium assistance programs, we will continue to require that such coverage be available after a six month period of uninsurance. However, this policy does not prevent States from covering SCHIP enrollees, whether children or families, through a separate child health program or through Medicaid. The final rule also permits States to adopt reasonable exceptions to the waiting period requirement. (See the discussion of the comments and responses on § 457.810.) Thus, the premium assistance substitution policy does not require that children be uninsured prior to enrolling in a premium assistance program.

Comment: One commenter believed that collaboration with the Child Support Enforcement Program is necessary and that any efforts to monitor potential substitution of private employer group coverage should include a review for coverage which may already be provided by a noncustodial parent, or which may potentially be available through a noncustodial parent pursuant to a support order. The commenter also asked that the definition of substitution be clarified and recommended a definition of ''equivalent to SCHIP coverage'' or some State-defined minimum requirements. The commenter appeared to believe that coverage inferior to SCHIP coverage carried by a noncustodial parent should not be considered health insurance coverage when determining whether SCHIP coverage is substituting for private group health insurance coverage.

Response: We agree that a State's SCHIP program should coordinate with the State's Child Support Program and that coverage under, or available through, a noncustodial parent's health plan should be considered by the State with respect to its substitution policies. The commenter is concerned that coverage available from the noncustodial parent be equal to SCHIP coverage or some State-defined minimum coverage before a concern for substitution should arise. We note that this final rule does not require that children be denied SCHIP coverage if the noncustodial parent has insurance that could cover the child. CSE agencies should be informed about the availability of SCHIP coverage because, as the commenter suggests, SCHIP coverage might provide better access to care than coverage potentially available through the noncustodial parent. The statutory provisions do, however, preclude SCHIP eligibility for a child who already has coverage under a group health plan or health insurance coverage, as those terms are defined under HIPAA. The only exceptions to this policy are if the child does not have ''reasonable geographic access'' to coverage, as described in subpart C, or if the policy meets the definition of ''excepted benefits'' under HIPAA.

3. Premium Assistance Programs: Required Protections Against Substitution (§ 457.810)

We proposed under § 457.810 to require any State that implements a separate child health program under which the State provides premium assistance for group health plan coverage, to adopt specific protections against substitution. A State must describe these protections in the State plan. In the NPRM, we proposed that the following four requirements would need to be met to protect against substitution:

• *Minimum period without group health plan coverage.* The child must not have been covered by a group health plan during a period of at least six months prior to application for SCHIP. States may require a child to have been without such insurance for a longer period, but that period may not exceed 12 months. States may permit exceptions to the minimum period without insurance if the prior coverage was involuntarily terminated. We noted that newborns who are not covered by dependent coverage would not be subject to a waiting period. We also noted that the waiting period applies only to coverage through a group health plan, not SCHIP or Medicaid coverage. If an otherwise eligible child does not meet the requirement for a minimum period without group health plan coverage, the State can enroll the child in SCHIP under a separate child health program without purchasing employer-sponsored coverage for the interim waiting period, and can still consider the child uninsured for purposes of the waiting period. That is, coverage under a separate child health program or Medicaid does not count as group health insurance coverage for purposes of the required waiting period prior to enrollment in SCHIP coverage provided via premium assistance programs.

• *Employer contribution.* The employer must make a substantial contribution to the cost of family coverage, equal to 60 percent of the total cost of family coverage. States proposing a minimum employer contribution rate below this standard must provide the Department with data that demonstrate a lower average employer contribution in their State and support a State's contention that the lower contribution level will be equally effective in ensuring maintenance of statewide levels of employer contribution. In addition, the employee must apply for the full premium contribution available from the employer.

• *Cost-effectiveness.* The State's payment under its premium assistance program must not be greater than the payment that the State otherwise would make on the child's behalf for other coverage under the State's SCHIP program.

• *State evaluation.* The State must collect information and evaluate the amount of substitution that occurs as a result of payments for group health plan coverage and the effect of those payments on access to coverage. To conduct this evaluation, States must assess the prior insurance coverage of enrolled children. States may obtain information on prior coverage through the enrollment process, separate studies of SCHIP enrollees, or other means for reliably gathering information about prior health insurance status. In the preamble to the NPRM, we set forth specific examples of questions States could include in SCHIP applications to evaluate the prevalence of substitution. We noted that we would reevaluate our position on the requirements for States that subsidize employer-sponsored plans based on our review of the State evaluations due March 31, 2000.

Comment: One commenter noted that employer ignorance of changing public benefit rules is one of the most effective safeguards against widespread substitution, and things such as competitive market pressures and rising health costs, not changing Medicaid and SCHIP coverage rules, drive reductions in employer subsidies for health

coverage. Further, the commenter stated that the safeguard of employer ignorance ends when the employer is contacted by a State agency and becomes a partner in purchasing SCHIP coverage. Another commenter indicated their belief that HCFA is inconsistent by indicating that it will scrutinize SCHIP programs subsidizing employer-sponsored insurance while suggesting (in § 457.90) that ''Employer-based outreach is another avenue for providing * * * information on children's insurance programs.''

Response: We note these comments and have sought to craft a substitution prevention policy that reflects the different pressures on the employer market and that balances States' desire for developing premium assistance programs with the risk that such programs will not expand coverage for children, but merely substitute employer contributions with SCHIP funds. There are both benefits and risks of partnering with employers in designing premium assistance programs. We have provided new flexibility to States to design such programs under these final rules, while retaining some requirements that are critical for preventing substitution.

Comment: Many commenters indicated their strong disagreement with the mandatory six-month minimum period without group health insurance coverage prior to application for SCHIP premium assistance coverage through group health plans. Their arguments against this policy included that it has no basis in statute, that it is inconsistent with other SCHIP strategies to prevent substitution which allow State flexibility, and that waiting periods block access to coverage and care for an arbitrary period without evidence of the effectiveness of any particular length of waiting period in preventing substitution. Some of these commenters added that if HCFA maintains a requirement for a period without employer-sponsored insurance prior to eligibility for SCHIP coverage obtained through premium assistance programs, that the minimum period be changed to 3 months. One commenter noted that there is no State system in place to confirm if and when an individual was previously covered under group health plans and that requiring States to establish such a system would be onerous and administratively costly.

Response: We have revisited and made revisions to our policy on substitution generally, and our policy on required periods of uninsurance, with respect to premium assistance for coverage under group health plans.

As discussed above, when a State operates premium assistance for group health insurance coverage, the State is no longer required to comply with the requirement that the employer contribution be at least 60 percent of the premium cost. The other requirements described in the proposed rule would continue to apply; namely, the requirements that the employee eligible for the coverage apply for the full premium contribution available from the employer, that such coverage be cost-effective, and that the State evaluate the amount of substitution that occurs as a result of payments for group health insurance coverage and the effect of those payments on access to coverage.

In addition, because of the greater likelihood of substitution of SCHIP coverage for group health insurance coverage offered by employers, we are retaining the requirement for a 6-month waiting period, but allowing States greater flexibility to vary from this general requirement. The default substitution prevention mechanism will be a period of uninsurance of at least six months, and not more than 12 months, without group health insurance prior to eligibility for SCHIP premium assistance for coverage through group health insurance plans offered by employers. States may also develop reasonable exceptions to the required waiting period when they can identify limited circumstances in which substitution is less likely to occur. For example, if a State is targeting its premium assistance program to certain employers that provide only very limited health insurance coverage, a waiting period may not necessarily be required since the likelihood of substitution would be limited in those circumstances.

In proposing exceptions to the six-month waiting period, States must provide reasonable justification for such exceptions, including data and other supporting evidence, as appropriate, which will be reviewed by HCFA in the context of the State plan amendment process. We have also listed several specific exceptions to the waiting period that may be granted, including involuntary loss of coverage due to employer termination of coverage for all employees and dependents, economic hardship, and change to employment that does not offer dependent coverage. And, as noted above, States also must monitor their premium assistance programs to determine whether substitution may be occurring. We plan to work closely with States interested in providing coverage via premium assistance for group health insurance coverage in order to provide technical assistance and help achieve a balanced approach that allows premium assistance plans to be implemented with appropriate safeguards to prevent substitution.

Comment: Many commenters expressed concern about the 60 percent employer contribution requirement at proposed § 457.810(b)(2) for SCHIP coverage provided through employer-sponsored insurance because employer contributions may vary in a State based on region, type and size of business, and wage levels of employees. The commenters' expressed the position that HCFA has exceeded its statutory authority in setting this benchmark, and they argued that it is unnecessary. Furthermore, the commenters stated that few employers contributing less than 60 percent of the premium would meet the required cost effectiveness test. The commenters noted that the statutory requirement that the purchase of employer-sponsored insurance with SCHIP funds must be cost effective is the most appropriate tool to use. One commenter indicated that the employer contribution standard should not be based on a statewide average of all businesses, but should be appropriate to, and specific to, those businesses which would participate in the SCHIP program that would utilize an existing health purchasing cooperative consisting of small businesses. One commenter also indicated that the level of substitution is unlikely to be affected by the 60 percent requirement, because employers would probably not base their health coverage decisions on the needs of employees eligible for premium assistance who, for many companies, represent only a small fraction of their overall employee pool. The commenter stated that crowd out occurs because of individual rather than corporate decisions, such as when individual employees elect to drop private coverage for low-cost or no-cost public assistance. Finally, the 60 percent would be problematic for some commenters' States because those States are operating under approved 1115 demonstrations to allow premium assistance when employers contribute at least half the cost of coverage.

Another commenter cited a survey that showed that in regions other than on the east coast, very few employers pay any part of the dependent premium. The recent survey indicated on average, large employers pay 85.51% of the employee premium and 17.62% of the dependent premium, and that small employers contribute 78.06% of the employee premium and 5.14% of the dependent premium. According to this commenter, HCFA's requirement

actually prevents access for many children.

Several commenters that disagreed with the 60 percent employer contribution requirement suggested it be deleted in favor of maintaining a cost-effectiveness test while requiring States to simply describe how they plan to monitor employer contribution percentages to detect any reductions in the contributions and assess whether reductions may be related to SCHIP premium assistance. Other commenters also recommended subjecting employers to a maintenance of effort requirement with respect to the contribution level.

One commenter recommended that if a minimum requirement is maintained, States be permitted to establish different standards for different kinds of employers, including making distinctions based on whether or not the employer has previously offered health insurance coverage and on the wage distribution of the employer's work force.

It was one commenter's opinion that failure to allow State flexibility on the employer contribution will stifle many potential innovative approaches to reach uninsured children of low-wage workers and that States will be unable to enroll sufficient numbers of children in these programs to justify the administrative expense. In addition, in this commenter's view, the 60 percent requirement may result in many families who would prefer premium assistance being forced to enroll their children in the regular SCHIP program, and force the State to forego any employer contribution. The commenter also noted that, if more low-wage workers decline dependent coverage when it is offered, employers with many low-wage workers may stop offering coverage, causing a long-term, population-wide shift from private to public sources of coverage.

Another commenter stated that the small employers in its State do not pay 60 percent of family health coverage premiums and, in fact, most do not cover dependents. The commenter believed that they should be allowed to include in premium assistance programs employers who are currently not covering dependents. They suggested a rule that would only include employers who did not cover dependents as of a certain date, or who paid less than a predetermined amount for coverage as of that date. The State would then use local objective data (and not ''outdated, national surveys of large employers'') to determine the contribution amount appropriate for the locality. One commenter indicated that our proposed policy would punish families who find jobs with employers who contribute less than 60 percent and encourage them to take jobs with employers that don't offer family coverage.

A commenter also suggested that whatever standard is adopted, there should be exceptions in instances in which employer contribution percentages drop solely because of an increase in premiums or where an employer drops its level of contribution because of documented and significant economic declines. In such cases, the commenter argued, crowd out isn't a factor in the reduced employer contribution level, and failure to allow employers in such circumstances to reduce their contribution levels may result in employees and their families losing their insurance. One commenter said, regarding the 60 percent employer contribution, that HCFA should not presume the cost neutrality of State initiatives to link title XIX/XXI coverage to low-wage workers, and said that the proposed regulations indirectly restrict a State's discretion to define eligibility and thereby exceed Congressional intent. Moreover, in this commenter's view, by establishing such a high level of employer contribution, HCFA effectively is excluding dependents of small business employees from participating in SCHIP.

Another commenter stated that a required percentage of employer contribution for participation in SCHIP premium assistance programs would give employers a target that could be misused. If an employer arbitrarily reduced its percentage of contribution, the employer could eliminate the opportunity for additional SCHIP-eligible employees to purchase employer health insurance with the help of premium assistance. In the commenter's State, only 2.5 percent of eligible individuals with access to employer-sponsored health coverage have access to family coverage where the employer pays 60 percent or more of the premiums. For nearly 30 percent of the State's eligibles with access to family coverage via an employer, the employer contributes about 10 percent less than the 60 percent minimum. In this commenter's view, our proposed rule would eliminate the opportunity for these individuals to be covered under a premium assistance program.

One commenter expressed disappointment that HCFA did not deviate from the policy expressed in the February 13, 1998 letter and indicated that the guidance is overly prescriptive and biased against the development of State approaches to SCHIP using employer-sponsored coverage. The commenter suggested providing additional State flexibility in determining the amount of employer contribution as long as plans certify that issues related to crowd out and substitution are addressed. If, upon evaluation, State efforts do not result in permissibly low levels of substitution, the commenter stated they would be happy to assist in the development of more detailed and specific guidelines. If the 60 percent requirement is not eliminated, this commenter suggested that States should be allowed to develop an alternative State average based on size of business, number of employees, number of low-wage employees or some other relevant factor.

Another commenter stated that there is no evidence in its Health Insurance Premium Program (HIPP) that employers have reduced their contribution because HIPP is paying the premium, and the commenter would not expect employers to act differently with respect to SCHIP. The commenter indicated that employers have other employees to consider and there is no evidence to support the position that employers will reduce their contribution because some employees are subsidized. They stated their belief that the majority of employers recognize the value of providing health care coverage to their employees and want them insured.

In this commenter's view, HCFA's position penalizes employees of employers who are not financially able or willing to contribute more, especially when health plans impose large premium increases. Also, the commenter believed that HCFA's position penalizes States by limiting their ability to buy-in to cost effective employer coverage and increasing the administrative burden for States. The commenter recommended that, if the employer plan is cost effective, States should have the flexibility to take advantage of the coverage, regardless of the amount of employer contribution.

Response: We appreciate the concerns raised by these commenters and we have revised our policy in this final rule to provide additional flexibility for States wishing to utilize premium assistance programs. We will no longer require States to implement a minimum employer contribution of 60 percent. We agree with the commenters' position that the cost-effectiveness requirement of the statute reduces the need for a uniform minimum employer contribution level, because it is likely that a substantial employer contribution would be necessary in order to meet the test of cost-effectiveness. However, States must identify a specific minimum employer contribution level to ensure

that SCHIP funds are used to supplement the cost of employer-sponsored insurance rather than supplant the employers' share of the cost of coverage, and we have maintained the requirement that States evaluate substitution in the context of their premium assistance program in their annual reports. While allowing for significant new flexibility, this policy also encourages States to require the highest possible employer contribution level that is reasonable given the circumstances in their State. In addition, the rules maintain the requirement that the employee eligible for the coverage must utilize the full premium contribution available from the employer.

We recognize that it may be necessary to revisit this policy as States gain experience with the provision of SCHIP coverage and we receive further evaluations of substitution with respect to SCHIP coverage provided through premium assistance for employer-sponsored insurance. The requirements set forth in this final rule represent our position on the steps necessary to implement the statutory provisions of section 2102(b)(3)(c) of the Act in light of what is now known about the interaction between private and public coverage. The rules provide considerable flexibility, allowing States and HCFA room to adjust the approach to substituion based on experience with the program.

Comment: One commenter agreed with the proposed rule's flexibility to allow less than 60 percent employer contribution to family coverage if the State average is less than 60 percent.

Response: We appreciate the support and as stated above, we have dropped the 60 percent contribution requirement in part because we recognize the variation in levels of average employer contributions across States.

Comment: One commenter strongly disagreed with our proposal to allow States to set a lower standard for employer contributions than 60 percent. The commenter asserts that because of the lack of data on ''average'' employer contributions to dependent coverage, especially with regard to small employers, and the fact that the average contribution among employers with 50 or fewer employees is zero percent, and in the commenter's State large employers also often contribute nothing, the commenter believes our proposed policy of allowing a less than 60 percent contribution would permit the allowance of premium assistance programs even where the employer contributes nothing at all.

Response: A contribution level of less than 60 percent is permitted under these final rules, as long as the cost-effectiveness test is met. We do not agree that premium assistance programs likely would be allowed when there is no employer contribution, as the commenter suggested, because the cost-effectiveness test is unlikely to be met without a substantial employer contribution.

Comment: One commenter suggested that HCFA clarify whether (and how) the NPRM's preamble discussion of determining cost-effectiveness under family coverage waivers applies with respect to using employer-sponsored insurance to provide coverage under SCHIP.

Response: The cost-effectiveness requirement in § 457.810(c) applies when a State provides premium assistance programs for SCHIP eligible children. The cost-effectiveness test for premium assistance for group health insurance coverage requires a comparison of the cost of coverage of the child that would otherwise be available under SCHIP to the State's cost to provide premium assistance for group health insurance coverage for that child. We have modeled the discussion of the cost-effectiveness test in the regulation text after the provision related to States that wish to cover family members, in addition to targeted low-income children at § 457.1015. We have specified that the State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children. Consistent with cost-effectiveness test for family coverage, the State may base its demonstration of cost-effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other SCHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

See the discussion at § 457.1015 for further details on cost-effectiveness for family coverage waivers.

Comment: One commenter indicated that the 60 percent requirement would unrealistically require a large base of employers to report data on contribution levels to the State in order for the State to satisfy the contribution requirement. Other commenters suggested we require States to evaluate the percent of income families would have had to spend to maintain employment-based or individual coverage during the period they waited for SCHIP coverage in assessing their substitution prevention procedures for their March 2000 evaluations and annual reports. They recommended that State evaluations and annual reports assess whether individual employers are terminating coverage for low-wage workers while maintaining coverage of higher wage workers and executives. Such an assessment should also examine increases in the amounts that employers are asking low-wage workers to contribute toward employment-based insurance coverage. Another commenter noted that few States will have implemented the employer buy-in option by the time of the March 2000 evaluations for HCFA to establish policy based on those evaluations.

Response: We are no longer imposing a minimum employer contribution requirement and recognize that there is not much experience to-date with premium assistance programs. As HCFA and the States gain experience, we will be in a better position to evaluate the extent of substitution taking place. We recognize that there is limited data regarding employer coverage and contributions based on wage-levels of employees as well as State based information on the percent of income families would have had to spend to maintain private coverage while waiting for SCHIP coverage. In addition, we note that market forces other than SCHIP may influence the level of employer contribution and further complicate such analyses. We encourage States to assess these issues but recognize that data to support such assessments may be difficult to obtain and therefore do not require it.

Comment: Several commenters noted concern about HCFA's policy permitting States to provide direct SCHIP coverage to children during the six-month waiting period via the State's separate child health program (other than premium assistance programs). Commenters indicated that this policy itself would actually facilitate crowd out as families dropped their privately-funded coverage in favor of publicly-funded benefits and that the privately-funded coverage would not resume until six months of publicly-funded coverage passed. In addition, one commenter noted that coverage under the State's regular SCHIP program is less cost-effective than its coverage under a premium assistance program.

Response: To the extent that the part of State's separate child health program that does not involve premium assistance requires either no period of uninsurance or a shorter one, there would be nothing to prohibit a child from being enrolled in that portion of the program even if the family had recently dropped coverage under its group health plan. There is no reason

that States should not be allowed to offer such coverage, although we believe it is unlikely that many families will drop their private group health insurance for coverage under a State's separate child health program, in part because most families would prefer to keep coverage of all the family members under one plan.

Comment: Many commenters suggested inclusion in the regulation of a mandatory list of exceptions to the proposed minimum 6-month waiting period and also encouraged the Department to prohibit waiting periods in excess of six months. Suggested exceptions included when: (1) An eligible individual is pregnant or disabled; (2) a waiting period exceeds the 63-day gap limit under HIPAA and would result in exclusion of coverage for a preexisting condition under the coverage offered by the State's separate child health program; (3) an eligible child is a newborn or recently adopted; (4) the waiting period would block coverage of a well-baby, well-child, or immunization service according to the periodicity schedules for such services; (5) insurance is lost because of involuntary job loss; (6) insurance is lost because of death of a parent; (7) insurance is lost because of a job change to employment where the new employer does not cover dependents; (8) a family moves out of the service area of employer coverage; (9) an employer terminates insurance coverage for all of its employees; (10) COBRA insurance benefits expire; (11) employment-based insurance ends because an employee becomes self-employed; (12) insurance is lost because of long-term disability; (13) insurance is terminated due to extreme economic hardship of the employer or employee; and (14) there is a substantial reduction in lifetime medical benefits or benefit category to an employee and dependents in an employee-sponsored plan. One of the commenters also suggested an exception when there has been a loss or termination of employer-based coverage due to affordability problems that would be determined based on a percentage of income. In addition, some commenters suggested exceptions when an eligible child has insurance that only provides limited coverage such as catastrophic coverage, hospital-only coverage, or scholastic coverage with very high deductibles, because these policies wouldn't allow access to preventive medical benefits.

Response: HCFA encourages States that impose waiting periods without group health coverage to consider adopting exceptions. Many States have adopted exceptions to the period of uninsurance based on a variety of factors. We have approved exceptions for reasons such as: loss of insurance due to involuntary job loss, death of a parent, change of employment where the new employer does not cover dependents; a family moved out of the service area of employer coverage; employer termination of insurance coverage for all employees; expiration of COBRA insurance benefits; end of employment-based insurance because an employee becomes self-employed; loss of insurance because of a long-term disability; termination of insurance due to economic hardship of the employer; when the family faces extreme economic hardship; and a substantial reduction in lifetime medical benefits to an employee and dependents in an employer-sponsored plan.

We have made several changes to the list of exceptions to the minimum period without coverage under a group health plan. States may allow for exceptions to the minimum period without coverage under a group health plan when the child's coverage is involuntarily terminated due to employer termination of coverage for all employees and dependents. We have added an exception for cases when there is a change in employment that does not offer dependent coverage.

In addition, States may provide an exception when the child's family faces economic hardship. While States have flexibility to define this term, examples of economic hardship could be families who are facing unusual economic difficulties, such as the loss of a home to fire, or high out-of-pocket costs due to a family member's illness not being covered by insurance. Another example would be if a State is targeting its premium assistance program to certain employers that provide only very limited health insurance coverage, a waiting period may not necessarily be required since the likelihood of substitution would be limited in those circumstances. Finally, we would consider an exception to the waiting period requirement if a State's proposal targeted low-wage employers in its premium assistance program, because substitution is much less likely when the coverage being subsidized is offered only by low-wage employers.

We anticipate that these reasonable exceptions will help facilitate States' ability to utilize premium assistance programs to enroll children in SCHIP.

Comment: One commenter noted that their State has had a Health Insurance Premium Payment (HIPP) program for Medicaid since July 1991. Under the HIPP program, the State pays the entire cost of the employee's share of the premium necessary to provide coverage to the Medicaid-eligible family members. Based on the State's experience with this program, they stated that they do not agree with our position that allowing States to assist families in the purchase of employer-related coverage will result in substitution of coverage. In fact, the commenter noted that as a condition of Medicaid eligibility, this State requires the family to maintain the insurance when it is cost-effective for the State to buy the coverage. This State argued that its policy supports the provision of premium assistance for employer coverage and avoids substitution because the State maintains the coverage for the family.

The commenter believed that HCFA's position actually promotes substitution of coverage by making it harder for States to buy-in to employer health plans when they become available and, thus, depriving the State of the opportunity to buy coverage that is more cost effective to the State.

The commenter was particularly concerned about our proposal because they have a strong HIPP program. It appears to the commenter that, if the State is purchasing employer coverage under the HIPP program for a Medicaid-eligible child, at the time the child transitions to their separate SCHIP program, the child has health insurance through an employer (although the State was paying for it), would result in the imposition of a 6-month waiting period before the child could be eligible for SCHIP and before the State could continue buying-in to the employer coverage. The commenter wanted the flexibility to maintain employer-sponsored coverage for children when they transition between Medicaid and the separate SCHIP program.

Response: We understand the commenter's concerns and acknowledge that substitution policies raise complex issues for which there are no clear answers. We have revised our policy in a number of ways to allow States greater flexibility to design premium assistance programs and we will continue to work with States as they evaluate how these programs are working and whether employer contributions are maintained. We note that in Medicaid, unlike SCHIP, having other health insurance coverage does not preclude eligibility for the program. With respect to the problem suggested by the commenter, we note that waiting periods do not apply when a child moves from a Medicaid program into a separate child health program because of an increase in family income, even if the Medicaid coverage was provided through an

employer-based plan such as the case with the HIPP program. In this case the child would be considered to have been covered by Medicaid, rather than by group health insurance coverage.

Comment: One commenter noted that if a family has to be uninsured for six months before the children can receive coverage through premium assistance for a group health plan, the family may miss the employer's open enrollment period while it waits to have access to premium assisted coverage.

Response: We note that the minimum waiting period requirement applies to the SCHIP-eligible child, not the entire family. Thus, for example, a parent could elect self-only coverage and decline dependent coverage, and enroll immediately in the employer-sponsored health insurance. Then, once the six-month waiting period had been satisfied, the parent could enroll the child(ren) at the next open enrollment period and obtain SCHIP premium assistance. States may cover SCHIP-eligible children in their regular SCHIP programs until such time as they can be enrolled in employer plans. Because § 457.810 gives effect to an important congressional purpose related to SCHIP coverage, we are maintaining the minimum waiting period in this circumstance. However, we suggest that States adopt rules, under the scope of their regulatory authority consistent with HIPAA, to require a special enrollment opportunity in group health plans based on a SCHIP-eligible individual or family becoming eligible to enroll in the plan under a premium assistance program.

Comment: One commenter suggested that the general provisions of proposed § 457.805, which say that ''The State plan must include a description of reasonable procedures to ensure that coverage provided under the plan does not substitute for coverage under group health plans . . . '' are sufficient and that proposed section § 457.810 (''Premium assistance programs: Required protections against substitution.'') should be deleted in order to allow States the flexibility to develop innovative approaches to utilizing employer-sponsored insurance coverage for SCHIP enrollees. The commenter indicated its belief that this approach would be in accord with Congress' intent that SCHIP programs be State-designed and State-operated, and that it would allow for the fact that private insurance markets and employer-sponsored health insurance patterns vary significantly from State to State. Proposed § 457.810 would make it very difficult for the implementation of employer-sponsored insurance under SCHIP.

Response: We understand the commenters concerns and have added some significant flexibility in this section of the final rule, as discussed above. We will work closely with States to develop premium assistance programs that fit their needs in the simplest and most operationally efficient way possible, while complying with the provisions of this final rule.

Comment: One commenter suggested that the language in § 457.810(a)(1) is poorly drafted and appears to imply that children uninsured more than 12 months would not be provided SCHIP coverage.

Response: We agree and have revised the language in § 457.810(a)(1) to clarify that a State, may not require a waiting period that exceeds 12 months.

H. Subpart I—Program Integrity

We proposed in subpart I to specify the provisions necessary to ensure the implementation of program integrity measures and enrollee protections within the State Children's Health Insurance Program. In addition, this subpart discussed the President's Consumer Bill of Rights and Responsibilities as it relates to the SCHIP program. This subpart also described how the intent of the GPRA can be upheld by including program integrity performance and measures as part of the State plans.

The grievance and appeal, and privacy-related issues addressed under this Subpart of the proposed regulation are now being addressed in the new Subpart K, Applicant and Enrollee Protections.

1. Basis, Scope, and Applicability (§ 457.900)

In § 457.900, we proposed under the authority of sections 2101(a) and 2107(e) of the Act to set forth fundamental program integrity requirements and options for the States. Section 2101(a) of the Act specifies that the purpose of the State Children's Health Insurance Program is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. In addition, section 2107(e) of the Act lists specific sections of title XIX and title XI and provides that these sections apply to States under title XXI in the same manner they apply to a State under title XIX.

The program integrity provisions contained in this subpart only apply to separate child health programs. States that implement a Medicaid expansion program are subject to the Medicaid program integrity provisions set forth in the Medicaid regulations at part 455, Program Integrity: Medicaid.

Comment: One commenter suggested that HCFA meet with the Office of the Inspector General to discuss fraud and abuse issues related to outreach to look at the legality of encouraging certain outreach strategies. The commenter noted that payment from a particular provider to a person, who the provider knows or should know would be likely to influence the individual to receive services, is prohibited.

Response: We appreciate the concern of the commenter. We routinely coordinate with the OIG regarding the review of existing and proposed regulations in accordance with the Inspector General Act, section 4(a)(2).

Comment: One commenter recommended that the entire Subpart be revised to be consistent with the requirements in the Medicare program. The commenter urged HCFA to adopt detailed requirements for both fee-for-service and managed care claims and suggested extensive revisions to the proposed rules. The commenter felt the need for flexibility did not justify State-by-State variation with respect to the applicability or enforcement of the False Claims Act.

Response: We disagree with this comment. The Medicare program is nationally funded and administered, while Medicaid and SCHIP are jointly-funded Federal-State programs that are administered by the States within broad Federal guidelines. Therefore, it would be inappropriate and infeasible to require SCHIP and Medicaid programs to conform to fraud and abuse prevention standards of an entirely Federally funded and administered program. In addition, while we recognize the significance of the False Claims Act, standardized claims requirements are not necessary for the efficient and effective operation of the SCHIP program, or for enforcement of the False Claims Act.

Comment: One commenter felt that HCFA over-emphasized the issue of program integrity at this point in the implementation process. They suggest that the States' scarce resources and personnel would be better focused on outreach, eligibility and enrollment rather than program integrity and fraud. This commenter commended our emphasis on the need for continuity with other State programs. One commenter recommended deleting §§ 457.915, 457.920, 457.925, and 457.930 because the commenter felt that the proposed rule should not mandate State activities that are subject to the

administrative cap and that are not specifically required in the statute.

Response: While we appreciate the commenter's concern, we disagree with the commenter's argument that we over-emphasized program integrity too early in the implementation process. We agree that outreach, eligibility, and enrollment are all important aspects of SCHIP programs and deserve adequate resources for development and implementation. However, program integrity initiatives are also necessary now that States' programs have been established. Program integrity is essential to protecting the SCHIP program from abuse and to ensuring that the program serves those it was intended to serve, uninsured low-income children. Therefore, to protect public funds from inappropriate and unintended uses and to preserve the SCHIP program, States must have a strong fraud prevention and detection plan early in program development so that it will be in place as programs develop and mature, and serve as a viable deterrent to potential fraud and abuse.

Comment: One commenter requested clarification on the issue of limitations on provider taxes and donations as it applies to the provider contribution toward family cost-sharing requirements.

Response: The donation rules at section 1903(w) of the Act govern donations by providers or related entities directly to the State, or to extinguish a State liability. Premiums are a liability of the recipient. When donations are given to the recipient, or to the State on behalf of the recipient, the liability of the recipient is reduced, not the liability of the State. As a reasonable safeguard, the sponsor paying the premium on behalf of the enrollee should either give the donation directly to the family, make the donation to the State tied to specific eligible individuals, or make the donation to the State which will in turn, designate the specific eligible individual(s). In the latter case, the State must assure donations are assigned to enrollees in a manner that does not favor higher income children over lower income children. In any case, the donation should not exceed the premium amount specified in the approved title XXI State plan. The section of the State plan related to cost sharing should describe the procedure for accepting such donations.

In addition, we note that providers are prohibited from giving enrollees anything of value that is likely to induce an enrollee to select a particular provider under the provisions of section 1128A(a)(5). Such conduct may subject the provider to civil monetary penalties under that section. This civil money penalty provision is administered by the Office of the Inspector General (OIG). In general, States are advised to avoid donations from providers for enrollee premiums that could unduly influence enrollees to select a particular health plan or provider. A State that is concerned that donations for enrollee's premiums may violate these provisions may wish to seek an advisory opinion from the OIG. See 42 CFR part 1008. The OIG will also participate in review of State plans or amendments proposing such donations.

Comment: One commenter noted that the many requirements included in this Subpart tacitly assume that the State will have a direct, contractual relationship with all SCHIP participating health plans, including premium assistance plans. However, they stated that, for premium assistance programs for group health coverage, no such contractual mechanism will exist. The employer, not the State, is the entity that contracts with the health plan; and the State is simply providing premium assistance to enable families to enroll their children in premium assistance programs, according to this commenter. Because there is no mechanism for enforcement here, the commenter stated that they are assuming that the requirements in this Subpart would not apply to employer plans. They suggested that the preamble should clarify this point. They cautioned that any attempt to apply requirements of this sort to employer plans will mean that no employer plans will ever qualify for premium assistance.

Response: While we have considered the commenter's concerns, States are responsible for the oversight of the use of public funds to provide child health assistance through premium assistance programs just as they are responsible for oversight in other types of children's health insurance programs. Consequently, it is not appropriate to make an exception from program integrity regulations for employer plans. In the case where the State has no direct contractual relationship with the entity providing health coverage, the State should utilize the fraud protections provided through the State insurance agency responsible for oversight of all commercial plans. For example, if State funds are provided under SCHIP to State-regulated health plans, the State insurance department anti-fraud component could conduct the State's anti-fraud oversight for its SCHIP funds. This final regulation provides flexibility to States for States to develop program integrity methods and systems that fit the needs of their particular SCHIP programs, whether or not those programs consist of premium assistance for group health plans.

2. Definitions (§ 457.902)

We proposed five definitions for the purpose of this subpart. We proposed that ''contractor'' means any individual or entity that enters into a contract, or a subcontract, to provide, arrange, or pay for services under title XXI. This definition includes, but is not limited to, managed care organizations, prepaid health plans, primary care case managers, and fee-for-service providers and insurers.

We proposed that a ''managed care entity'' is any entity that enters into a contract to provide services in a managed care delivery system, including, but not limited to managed care organizations, prepaid health plans, and primary care case managers. We proposed that ''fee-for-service entity'' means any entity that provides services on a fee-for-service basis, including health insurance services. We proposed that ''State program integrity unit'' means a part of an organization designated by the State (at its option) to conduct program integrity activities for separate child health programs.

Finally, we proposed to define the term ''grievance'' as a written communication, submitted by or on behalf of an enrollee in a child health program, expressing dissatisfaction with any aspect of a State, a managed care or fee-for-service entity, or a provider's operations, activities, or behavior that pertains to specified areas, including the availability, delivery or quality of health care services, payment for health care services and other specified areas. The grievance and appeal, and privacy-related issues addressed under this Subpart of the proposed regulation are now being addressed in the new Subpart K, Enrollee Protections.

Comment: A few commenters suggested that the definitions of ''fee-for-service entity'' and ''contractor'' raised a potential inconsistency in that the term ''fee-for-service entity'' does not include ''individual or entity'' as ''contractor'' does. This suggests that individual physicians or other practitioners are exempted from the requirement at § 457.950 to attest that any claims submitted for payment to be accurate, complete and truthful. The commenters noted that these practitioners are currently required to make this certification under Medicare and Medicaid.

Response: We agree with the comment and have modified the regulation text accordingly. We note again that we have created a new subpart intended to address more specifically the issues related to enrollee protections and because the term ''contractor'' will now apply to both this subpart and the new subpart K, we have moved the definition to § 457.10.

3. State Program Administration (§ 457.910)

In § 457.910 we proposed that the State child health plan must provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the separate child health program. We also proposed that the State's program must provide the safeguards necessary to ensure that eligibility will be determined appropriately in accordance with Subpart C of this regulation, and that services will be provided in a manner consistent with administrative simplification and with the provisions of Subpart D—Coverage and Benefits.

Comment: One commenter noted that the preamble language states that the Secretary wishes to give States ''maximum flexibility'' in the administration of their SCHIP programs. However, the commenter felt that the literal interpretation of this language translated into ''methods of administration that the Secretary finds necessary,'' giving the Secretary too much discretion to impose methods of administration on States.

Response: We understand the commenter's concerns. The commenter is correct that the Secretary has a great deal of discretion over the requirements of the SCHIP program. We remain committed to providing States with flexibility in the administration of their SCHIP programs but, as stated in the preamble to the proposed regulation, we seek to balance this need against the Federal government's need to remain accountable for the integrity of the program. The provisions of the regulation reflect this balance and the basic framework within the regulation is necessary to ensure the integrity of SCHIP. However, this framework does not dictate to the States what methods of administration they must use to prevent and detect fraud and abuse, thereby leaving the States with significant flexibility to administer SCHIP programs.

Comment: One commenter encouraged HCFA to ensure administrative simplification, not only in the operation of the program, but in the provision of services and with respect to providers.

Response: HCFA is committed to policy approaches that minimize the administrative burden that is placed on States in implementing their SCHIP programs in general. In addition, we are mindful of the need to strike a balance between ensuring access to SCHIP coverage, and the benefits provided under that coverage, without making it unduly burdensome for States to accomplish these goals. However, these rules address State requirements and are not intended to address State relationships with providers, which are a contractual matter between the State and providers.

4. Fraud Detection and Investigation (§ 457.915)

Section 2107(e) references sections 1903(i)(2) and 1128A of the Act, which provides a basis for certain fraud detection and investigation activities. Section 2107(e) states that these provisions apply under title XXI in the same manner as they apply to a State under title XIX. Moreover, these provisions are cited as authority in the Medicaid regulations at part 455, Subpart A—-Medicaid Agency Fraud Detection and Integrity Program. In the proposed rule, we discussed in detail three possible options we considered to ensure that separate child health programs develop and implement adequate fraud detection and investigation processes and procedures. We concluded that the best approach would be to require States to address, specifically, the Medicaid goals for fraud detection and investigation, but to allow States to design specific procedures needed to meet the requirements of § 455.13. We chose neither to require States with separate child health programs to follow the same procedures for fraud detection and investigation as the Medicaid program, nor did we provide States with full latitude in designing processes and procedures. We stated that this approach balances the need for maintaining State flexibility while establishing an acceptable minimum standard that will satisfy our need for accountability in the program.

We proposed that the State must establish procedures for assuring program integrity and detecting fraudulent or abusive activity. We also proposed that the procedures must include, at a minimum, the methods and criteria for identifying suspected fraud and abuse cases as well as methods for investigating fraud and abuse cases that do not infringe on the legal rights of persons involved and afford due process of law. The State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program, which is referred to in subsequent provisions of the regulation as the ''State program integrity unit''. We further proposed that the State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit (if such a unit is established) and to law enforcement officials. Law enforcement officials include, but are not limited to, the Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), the Federal Bureau of Investigation (FBI), and the State Attorney General's office.

Comment: One commenter commended HCFA for recognizing that separate child health programs should not be expected to have the same fraud detection and infrastructure as required under Medicaid. However, the commenter felt that by tying goals to Medicaid fraud and abuse goals, as well as recommending the use of the State program integrity unit, HCFA was pushing the States toward Medicaid procedures without backing them up with sufficient funding levels.

Response: While we understand the commenter's concern, we specifically set out in the proposed rule a framework that attempted to provide flexibility to the States, while ensuring that States include basic, necessary protections against fraud. We are not requiring States to establish State program integrity units or to use Medicaid fraud and abuse methods or procedures to ensure the integrity of the SCHIP program. We invite States to design program integrity plans and procedures that are specific to the needs of their unique SCHIP programs within the broad framework required by the final rule. The flexibility afforded the States in this regulation allows them to structure program integrity activities that limit the administrative burden, but still ensure the integrity of the program.

Comment: One commenter found the rules overly prescriptive and recommended the elimination of paragraph (b) that describes the ''State program integrity unit'' and the deletion of the requirement to refer program integrity cases to law enforcement officials in (c).

Response: The rule encourages, but does not require, States to develop or use an entity that could be called a ''State program integrity unit''. This concept was developed in an attempt to give the States a framework to set up an effective program integrity strategy. While not required, we believe the

development of such a unit would be very beneficial to the States in designing systems to address these issues. In addition, because of Medicaid statutory provisions, States are not permitted to use existing Medicaid fraud control units (MFCUs) to conduct SCHIP program integrity activities. (While MFCUs have been given additional flexibility under the Ticket to Work Incentives Improvement Act of 1999, this flexibility only applies in cases that primarily involve Medicaid funds.) In general, States are limited to using Medicaid funds for Medicaid activities. If a State wanted to utilize the MFCU, it could only do so by hiring new staff that would be exclusively responsible for SCHIP program integrity activities and are funded by title XXI funds. (We note that this new, separately funded ''branch'' of the MFCU could be called the ''State program integrity unit''.) Therefore, we will not eliminate § 457.915(b). Finally, the inclusion of, and coordination with, appropriate Federal and State law enforcement officials as part of a State's overall fraud detection efforts, and overall program integrity efforts, is vital to the effectiveness of its program integrity activities. Therefore, we will not eliminate § 457.915(c).

Comment: Several commenters noted that they appreciated the need for fraud and abuse protections, and hoped HCFA was allowing flexibility for States to utilize provider fraud detection processes of participating health plans or other State insurance department procedures. Also, these commenters hoped that States would be given sufficient time to implement these procedures.

Response: These final rules provide a structure under which States have the flexibility to use a variety of methods to create a comprehensive fraud detection strategy. While we envision that the State insurance departments may play an important role for a State in SCHIP fraud and abuse detection and investigation, we anticipate that States may want to complement those procedures already performed by the State insurance departments with procedures and goals specific to SCHIP. Specifically, fraud and abuse stemming from procedures for, or other aspects of, participant enrollment in the separate child health program would raise distinct issues that likely fall outside of procedures established by State departments of insurance as they monitor private health plans and issuers outside of the SCHIP context. States must also address the concern that fraud and abuse may occur within a participating health plan apart from provider fraud and therefore, States must have additional procedures to detect and investigate fraud within plans. Therefore, relying on plans' processes to monitor provider fraud, while potentially useful, would not sufficiently protect against the varied types of fraud and abuse that could impact the SCHIP program in a State.

We note the commenters' concern that States need a reasonable amount of time to implement new Federal requirements. We will require that States come into conformity with new requirements within 90 days of publication of this rule, or if contract changes are necessary, the beginning of the next contract cycle. In limited cases where a new regulatory provision requires a description of procedures in the State plan, then the State must implement the procedures within the above time frame and submit the State plan amendment in compliance with § 457.65(a)(2).

Comment: One commenter noted that precise, professional guidelines regarding care issues, industry-accepted standards for fair and reasonable audits, and investigations with due process protections for providers, are essential to expand access under SCHIP.

Response: The best means of expanding access to care under SCHIP is to allow the States sufficient flexibility in designing program integrity procedures and methods as well as other aspects of their programs while maintaining a framework of Federal requirements consistent with title XXI. We encourage States to develop precise, professional guidelines as part of the design of State fraud detection and investigation methods. In addition, States should refer to industry standards in establishing audit processes as appropriate. Section 467.915(a) specifies that States must establish procedures for investigating fraud and abuse cases that do not infringe on legal rights of persons involved and afford due process of law. These requirements apply to investigations of all types of fraud and abuse under the separate child health program, including investigations that involve providers.

Comment: One commenter recommended that the language in this section be expanded to include use of procedures already in place that support these activities. In addition, they suggested revising § 457.915(c) to clarify that suspected fraud and abuse cases should be referred to ''appropriate'' law enforcement officials as determined by State law.

Response: We have revised the regulation text at § 457.915 to clarify that States must develop and implement procedures for referring suspected fraud and abuse cases to appropriate law enforcement officials, although we have not included the commenters' recommended language ''as determined by State law'' because referrals could be made to Federal law enforcement officials, as appropriate. We have listed certain law enforcement officials under § 457.915(c) because States may wish to contact these officials with fraud and abuse information to facilitate program coordination. This is not intended to be an exhaustive list of all law enforcement officials States may contact, nor is referral to all these entities required, unless it is appropriate.

5. Accessible Means To Report Fraud and Abuse (§ 457.920)

We proposed that States with separate child health programs must establish, and provide access to, a mechanism of communication between the State and the public about potentially fraudulent and abusive practices by and among participating contractors, beneficiaries, and other entities. We noted in the preamble to the proposed regulation that this communication mechanism may include a toll-free telephone number, and also noted that States are free to use their discretion regarding whether to establish toll-free services for these purposes alone or to expand upon existing services. We noted that access to toll-free service for the reporting of potentially fraudulent and abusive practices is a integral part of any sound program integrity strategy.

Comment: One commenter recommended that this provision be deleted because the rule should not mandate State activities that are subject to the administrative cap and are not specifically required by the statute.

Response: We acknowledge the commenters' point and agree that this section should be deleted. However, we have deleted this section because while we do have statutory authority to include such a provision, the provision was unnecessary and somewhat redundant.

6. Preliminary Investigation (§ 457.925)

We proposed that if the State receives a complaint of fraud or abuse from any source, or identifies any questionable practices, the State agency must conduct a preliminary investigation or take otherwise appropriate action to determine whether there is sufficient basis to warrant a full investigation. We noted in the preamble, consistent with § 457.915(b), that the State has the option of creating a ''State program integrity unit'' for separate child health

programs that would be responsible for monitoring and maintaining the integrity of the separate child health program. We also noted that each State has flexibility to define the role played by such units but that fraud and abuse activities relating to SCHIP must be funded with monies from the State's SCHIP allotment. Finally, while we proposed that preliminary investigations be conducted under the circumstances specified in § 457.925, we remained flexible with regard to the processes and procedures that separate child health programs employ in conducting preliminary investigations and did not require or specify the procedures States must take to conduct their investigation in compliance with this requirement.

Comment: One commenter recommended that this provision be deleted because the rule should not mandate State activities that are subject to the administrative cap and are not specifically required by the statute.

Response: We disagree that this section should be deleted. As noted earlier, we maintain that these program integrity activities are necessary for the effective and efficient administration of the State plan as required in § 2101(c)(2) of the statute, in addition to being based on the sound precedents set by the Medicare and Medicaid programs.

Comment: One commenter recommended that HCFA specify that States must undertake a preliminary investigation within a reasonable time not to exceed 60 days.

Response: We agree with the commenter's suggestion that a State must undertake a preliminary investigation within a certain amount of time. We have not prescribed a specific number of days, but suggest that 60 days is indeed a reasonable amount of time to undertake a preliminary investigation. We have made the appropriate change to the regulation text.

7. Full Investigation, Resolution, and Reporting Requirements (§ 457.930)

We proposed that the State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. We further proposed that, once the State determines that a full investigation is warranted, the State must implement certain procedures, including, but not limited to, the procedures specified at paragraphs (a) through (c) of § 457.930.

We noted in the preamble to the proposed rule that States may model their approaches after procedures for fraud and abuse investigation, resolution, and reporting used by the Medicaid State agency as outlined in §§ 455.15, 455.16, and 455.17 of the Medicaid regulations. Medicaid funding cannot be used for fraud investigation activities in separate child health programs. MFCUs may only use Medicaid funding for fraud and abuse activities in States that provide child health assistance under a Medicaid expansion program. MFCU professional staff being paid with Medicaid dollars must be full-time employees of the Medicaid fraud agency and devote their efforts exclusively to Medicaid fraud activities. To the extent that States want to allocate additional non-MFCU full-time staff, using SCHIP dollars, to work exclusively on fraud and abuse investigation in separate child health programs, they may do so. We noted that expenditures for this purpose would be subject to the 10 percent cap on administrative costs under section 2105(c)(2) of the Act.

Comment: One commenter suggested that a better alternative to traditional law enforcement would be to work through the provider fraud processes established by participating health plans, under which the expenditures might be considered a benefit cost rather than an administrative cost.

Response: While we intended to provide flexibility in implementing program integrity strategies, as noted in response to a comment on § 457.915, States must be aware that fraud and abuse may stem from within a participating health plan or apart from providers. Therefore, States must have procedures at the State level to detect and investigate plan and issuer fraud and abuse, as well as provider fraud and abuse. Relying on plan and issuers to monitor themselves for fraud and abuse would not be in the public interest.

It is true that capitated payments made to plans in conjunction with the provision of health benefits coverage that meets the requirements of title XXI and for which the plan is at risk are not considered administrative costs. Therefore, plan activities covered by these payments are considered as expenditures for child health assistance. However, health plan processes for the detection, investigation and resolution of fraud and abuse, and that protecting program integrity is not the only concern States must consider in designing their program integrity strategies. They must design strategies that accomplish the goals of, and comply with the requirements of, this subpart, thereby protecting against a range of potential fraud and abuse concerns, such as, but not limited to, any potentially problematic health plan activity.

Comment: Several commenters recommended that HCFA allow States the authority to enter into agreements with other investigative bodies, not strictly law enforcement officials, and not necessarily a State-established program integrity unit; rather, they recommended that States be able to contract with bodies such as health plan investigative divisions. To this aim, commenters recommended paragraph (c) be rewritten to include referring the fraud and abuse case to an appropriate investigative body as designated by the State.

Response: We agree that States should be able to structure their fraud and abuse activities in different ways; however, the inclusion of coordination with any law enforcement officials is an integral part of an effective program integrity process. We have modified the regulation text to clarify that State should be able to determine the appropriate law enforcement officials to whom they should refer suspected fraud and abuse cases but we do not agree with the recommendation that States should not have to coordinate with any law enforcement officials. We reserve the right to review the States' program integrity procedures to ensure their compliance with the requirements and goals of title XXI and this regulation.

Comment: One commenter believed that it is unreasonable to judge States' applications or amendments based on consistency of their fraud and abuse procedures with other State programs.

Response: States are required to design and implement procedures for fraud investigation, resolution, and reporting. States are not required to file State plan amendments with HCFA in order to implement a program integrity fraud and abuse detection and investigation strategy. Therefore, HCFA will consider State's statement assuring the development and implementation of a program integrity system to be a requirement that is subject to review through HCFA's ongoing monitoring.

Comment: We received a few comments noting that requiring States with separate child health programs to set up separate structures other than Medicaid Fraud Control Units to do the same function is a waste of resources, and that requiring separate processes is burdensome and costly. One commenter recommended that States have the option to allow the MFCU to conduct SCHIP fraud investigations, assuming tracking and claiming are conducted appropriately. Another commenter recommended deleting the provision because the rule should not mandate

State activities that are subject to the administrative cap and are not specifically required by the statute.

Response: As noted above, the Medicaid statute does not permit MFCUs to conduct program integrity activities that are not related to the Medicaid program. We disagree that this section should be deleted. We maintain that program integrity activities are necessary for the effective and efficient administration of the State plan as required in section 2101(c)(2) of the statute, in addition to being based on the sound precedents set by the Medicare and Medicaid programs. While we recognize that some of these activities could be duplicative, we do not have the authority to blend the funding for fraud and abuse prevention efforts among the Medicaid and SCHIP programs.

Comment: One commenter suggested that States must have *written* procedures for investigating and resolving suspected and apparent instances of fraud and abuse.

Response: We agree that States should have written procedures for investigating and resolving suspected and apparent instances of fraud and abuse to ensure the effective and efficient administration of SCHIP programs. However, we are not requiring that States submit to HCFA such written procedures. We anticipate that States may continue to develop and to modify fraud investigation and detection procedures as SCHIP programs develop. Therefore, we anticipate the methods and rules relating to program integrity will evolve as they are implemented. We wish to give the States the flexibility to improve fraud and abuse detection systems as they develop, rather than tying States to an initial written plan. However, HCFA reserves the right to review a States' program integrity procedures, and to request that they be described in writing, as part of its ongoing monitoring.

8. Sanctions and Related Penalties (§ 457.935)

Under the authority of sections 2101(a) and 2107(e) of the Act, and consistent with the requirements under Federal and State health care programs, we proposed that a State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any contractor who has been excluded from participating in the Medicare and Medicaid programs. We noted that this provision is necessary to implement section 1128 of the Act regarding exclusion of certain individuals and entities from participation in Medicare and State-administered health care programs. We proposed that the separate child health programs be subject to program integrity provisions set forth in the Act including: (1) Section 1124 relating to disclosure of ownership and related information; (2) section 1126 relating to disclosure of information about certain convicted individuals; (3) section 1128A relating to civil monetary penalties; and (4) section 1128B(d) relating to criminal penalties for acts involving Federal health programs. We also proposed to make separate child health programs subject to Part 455, subpart B of chapter IV of title 42 of the Code of Federal Regulations. In an effort to promote enforcement of this subsection and to provide HCFA and the Secretary with critical fraud and abuse data, we also proposed that the separate child health programs be subject to the requirements of section 1128E of the Act in the same manner as under the Medicare and Medicaid programs. In accordance with section 1128E of the Act, we proposed that the separate child health program be subject to the requirements pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners. In addition, we noted in preamble that States should share such information and data with the Office of the Inspector General in an effort to promote enforcement.

We did not receive any comments on this section and will therefore implement the regulation language as proposed.

9. Procurement Standards (§ 457.940)

Section 2101(a) of the Act requires that States provide services in an effective and efficient manner. In order to meet our obligation to ensure that States use SCHIP funds in a cost-effective manner, we set forth provisions at proposed § 457.940 regarding procurement standards. The proposed provisions did not include Federal oversight of provider payments. Rather, we proposed to require that States set rates in a manner that most efficiently utilize limited SCHIP funds.

We proposed to require that States provide HCFA with a written assurance that title XXI services will be provided in an effective and efficient manner. We also proposed that the assurance must be submitted with the initial SCHIP plan or, for States with approved SCHIP plans, with the first request to amend the SCHIP plan submitted to HCFA following the effective date of these regulations.

If States contract with entities for SCHIP services, they must provide for free and open competition, to the maximum extent possible, in the bidding of all contracts for coverage or other title XXI services in accordance with the procurement requirements of 45 CFR 74.43.

Alternatively, we proposed that States may base title XXI payment rates on public or private payment rates for comparable services. We noted in preamble that this applies to fee-for-service and capitated rates. We proposed that, if a State finds it necessary to establish higher rates than would be established using either of the above methods, it may do so if those rates are necessary to ensure sufficient provider participation or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services. For example, this method will allow States the flexibility to establish higher rates to attract providers in under-served areas or to enroll more costly specialty providers.

We also proposed that States must provide to HCFA, if requested, a description of the manner in which they develop SCHIP payment rates in accordance with the requirements of §§ 457.940(b)(2) and (c). The description would include an assurance that the rates were competitively bid or an explanation of the applicability of the exceptions of 45 CFR part 74, or a description of the public or private rates that were used to set the SCHIP rates, if applicable, and/or an explanation of why rates higher than those that would be established using either of these two methods are necessary. HCFA may request the description when a State first determines its rates or, for approved SCHIP plans, when it updates its rates or changes its reimbursement methodology.

Comment: We received several comments recommending with regard to § 457.940(b)(1) that procurement standards in 45 CFR part 92 are more appropriate for non-entitlement programs such as SCHIP because they allow States to utilize their own procurement standards when purchasing services with Federal grant money. Flexibility will enable States to make cost-effective and quality health plan selections. One commenter noted that flexibility to establish higher rates to ensure provider participation should be coupled with stricter enforcement.

Response: We disagree with the commenter's suggestion for changing the procurement standards applicable to SCHIP. We believe the procurement requirements of 45 CFR 74.43 are more appropriate for separate child health

programs because they allow for accountability as well as State flexibility in implementation. We expect all States, not just those establishing higher rates to ensure provider participation or for other permitted purposes, to strictly enforce the procurement standards of this section.

Comment: Several commenters requested that § 457.940(b)(2) be rewritten as follows: ''Basing title XXI payment rates on public and/or private payment rates for comparable services for comparable populations.'' Several commenters felt this section should be expanded to allow States, where such comparisons cannot be made for lack of data, the ability to explain their analysis of why the rates are within acceptable parameters.

Response: We acknowledge the distinctions in rates that may need to be made based on the populations being served and have added ''for comparable populations'' to the regulation text as recommended. However, we disagree with the suggestion to change the regulation to allow States to explain why the payment rates are within acceptable parameters absent sufficient supporting data. The final regulation text includes a significant amount of flexibility for States to explain how they meet the standards of § 457.940(c) regarding the need for higher rates than otherwise permitted and received many comments recognizing its flexibility. We have retained the proposed language in § 457.940(c) regarding acceptable bases for such higher rates because we believe rates should only be permitted to be higher under those specific circumstances.

Comment: One commenter supported the intent of the section and noted the importance of setting adequate reimbursement levels to ensure provider participation and efficient provision of services. The commenter found it problematic that about half of the States set payment rates for separate child health programs at the same levels as they do for Medicaid. The commenter encouraged HCFA to work with States to establish more reasonable rates.

Response: Each State has the authority to set reasonable rates for its SCHIP population providers. It would be inappropriate for us to dictate to the States what specific rates they should pay to participating providers, especially in those States that have a sufficient number of providers to furnish quality care to all SCHIP participants. However, in accordance with § 457.495, we encourage States to set rates and generally administer their SCHIP programs in a way that will provide access to providers and attract an adequate number of highly qualified, experienced providers with the appropriate range of specialties and expertise.

Comment: One commenter suggested that HCFA incorporate a standard that the SCHIP rates for MCEs be actuarially sound and that we should clarify the meaning of actuarial soundness in the managed care context. In addition, another commenter suggested that HCFA require States to justify or prove the methodology used to establish the payment rate.

Response: We agree with the comment that rates should be actuarially sound. Actuarially sound capitation rates means that they have been developed in accordance with generally accepted actuarial principles and practices, that are appropriate for the populations and services to be covered under the contract, and that have been certified by an actuary (or actuaries) meeting the qualification standards established by the Actuarial Standards Board. The text of the regulation at § 457.940(b)(3) has been changed to reflect this and a definition is included at § 457.902—Definitions.

Comment: One commenter supported giving States maximum flexibility to take advantage of local market forces in establishing SCHIP payment rates. In this commenter's view, States should provide reimbursement for obstetric and gynecologic services sufficient to assure that SCHIP enrollees have access equal to that of privately insured patients. This commenter also noted that providing these types of services to adolescents is often quite time consuming due to the various developmental and psycho social issues they face, and recommended that compensation for physicians should be determined accordingly.

Response: We appreciate support for the policy of giving States flexibility in their procurement and rate setting. However, it is important for States to set rates high enough to provide sufficient access to, and quality of, care for all SCHIP participants for all services. However, it is not appropriate to specify the need for enhanced payment rates for certain types of providers or services in regulation. The requirement that States provide for free and open competition in procurement or demonstrate that their rates meet the requirements of (b) or (c) should ensure that SCHIP enrollees have access to providers that are compensated appropriately within their local health care markets.

Comment: We received one comment recommending that § 457.940(a) include a specific reference that States must comply with all applicable civil rights requirements in accordance with § 457.130.

Response: Section 457.130, contained in subpart A (which is the subpart that sets forth many general State plan requirements), requires States to include in their State plan an assurance that the State will administer their SCHIP program in compliance with applicable civil rights requirements. We maintain that this provision sufficiently assures this compliance.

10. Certification for Contracts and Proposals (§ 457.945)

In addition to the proposed requirements in § 457.950, which specify that contractors must certify that payment data is accurate, truthful, and complete, we proposed to specify in § 457.945 that entities that contract with the State under a separate child health program must also certify the accuracy, completeness, and truthfulness of information in contracts, and proposals, including information on subcontractors, and other related documents, as specified by the State.

Comment: One commenter asserted that the requirements in this section are overly burdensome for States. Because so many of the SCHIP programs utilize managed care delivery systems, the commenter noted that managed care entities are required, by virtue of executing their contracts with the States, to provide accurate, complete and truthful information. The commenter felt that a separate and distinct certification document is unnecessary.

Response: While we appreciate the administrative challenges States may face in implementing SCHIP programs, we do not believe the requirements of this section are overly burdensome for States. The unique nature of the SCHIP program and its relationship with plans and issuers merits the inclusion in contracts of the specific certifications required by this section, and that compliance with this standard will protect against fraud and abuse in this government-funded program. The commenter may have interpreted this provision to require a separate certification document but, in fact, the required certification could be provided as part of, or together with, any of the contracts or related documents into which the State and its contractors have entered, and should entail minimal additional administrative effort.

11. Contract and Payment Requirements Including Certification of Data that Determines Payment (§ 457.950)

At § 457.950, we proposed that when SCHIP payments to managed care

entities are based on data submitted by the MCE, the State must ensure that its contracts with MCEs require the MCE to provide enrollment information and other information required by the State. We also proposed that the State ensure that its contract requires the MCE to attest to the accuracy, completeness, and truthfulness of claims and payment data, upon penalty of perjury. As a condition of participation in the separate child health program, MCEs must provide the State with access to enrollee health claims data and payment data, as determined by the State and in conformance with the appropriate privacy protections in the State. We also proposed that managed care contracts must include a guarantee that the MCE will not avoid costs for services, such as immunizations, covered in its contract by referring individuals to publicly supported health care resources (for example, clinics that are funded by grants provided under section 317 of the Public Health Service Act).

We proposed that when SCHIP payments are made to fee-for-service entities, the State must establish procedures to ensure and attest that information on provider claim forms is truthful, accurate, and complete. We also proposed that, as condition of participation in the State plan, fee-for-service entities must provide the State with access to enrollee health claims data and payment data, as determined necessary by the State.

Comment: One commenter agreed that agents of the State need access to payment information and that payment decisions must not be made without proper information and involvement of providers.

Response: We appreciate support for the requirements in § 457.950 regarding State access to claims and payment data. As noted in the preamble, compliance with § 457.950(b)(2) requires States to establish procedures to ensure and attest to the accuracy of information on provider claim forms. The State thereby must involve the provider community to the extent necessary to comply with this requirement and the rest of § 457.950, as noted in the comments.

Comment: One commenter recommended amending this section to include a requirement to comply with applicable civil rights requirements in accordance with § 457.130.

Response: Section 457.130 requires States to administer the entire SCHIP program in compliance with the Civil Rights requirements noted in the title XXI statute and we maintain that this provision sufficiently assures compliance.

Comment: One commenter noted that the wording of this section is confusing. The commenter noted that because some States may make prospective monthly payments to MCEs on the first day of each month, the MCE may not have any information other than the enrollment forms from the State itself. These States may be unclear as to whether or not this section applies to their programs.

We also received a few requests that the requirement to attest to the accuracy and completeness of the data reflect that, to the extent that data is based on projections (e.g. premium rate submissions) that plans be permitted to attest to the accuracy to the best of their knowledge, information and belief. Another commenter requested deletion of the phrase ''under penalty of perjury'' from paragraph (a) because the requirements are already enforced through contractual language and penalties. Also, commenters requested clarification that complete data refers to data that includes all elements required by the State.

Response: One of the fundamental tenets of program integrity is the need for certification of payment-related information. Prospective monthly payments are based on certified payment-related information despite the fact that they are developed retrospective of the services delivered. The submission of enrollment forms does not constitute payment-related information.

While we recognize that the clause ''under penalty of perjury'' at § 457.950(a) may not have been appropriate for the entire paragraph, the Office of the Inspector General representatives indicated that it was an essential protection. Therefore, we have deleted ''under penalty of perjury'' from the general language of § 457.950(a), but left it in § 457.950(a)(2).

12. Conditions Necessary to Contract as a Managed Care Entity (MCE) (§ 457.955)

In addition to implementing program integrity protections at the State level, we proposed under § 457.955 that the State must ensure that MCEs have in place fraud and abuse detection and prevention processes. These processes would include mechanisms for the reporting of information to appropriate State and Federal agencies on any unlawful practices by subcontractors of or enrollees in MCEs. In order to maintain privacy protections for enrollees, we proposed that the reporting of information on enrollees would be limited only to information on violations of law pertaining to actual enrollment in the plan or to, provision of, or payment for, health services. Furthermore, we proposed that the State maintains the authority and the ability to inspect, evaluate and audit MCEs, as determined necessary by the State in instances where the State determines that there is a reasonable possibility of fraudulent or abusive activity.

We noted in the preamble that States that have Medicaid expansion programs and contract with MCEs under section 1903(m) of the Act may arrange for an annual independent, external review of the quality of services (EQR) delivered by each MCE as provided for under section 1932(c)(2) of the Act. States are permitted to draw down 75 percent FFP for this activity. States with separate child health programs are encouraged to provide for EQR of each MCE under contract to provide services to SCHIP enrollees; however, expenditures for EQR would be subject to the 10 percent limit for administrative expenses under section 2105(c)(2) of the Act.

Comment: Several commenters suggested that separate SCHIP programs should not be required or encouraged (as in the preamble) to use the Medicaid external quality review of services and that there is inequity in that Medicaid expansion programs receive 75 percent FMAP for this activity while stand-alone programs are required to stay within the 10 percent limit on administrative expenditures.

Response: While the Medicaid EQR process is a good model for States implementing separate child health programs, we are not requiring the use of this process in the regulation text, therefore States have flexibility in determining the type of quality assurance processes they utilize. Thus, States retain discretion in the use of funds for administrative expenditures and how to stay within statutory limits on such expenditures.

Comment: One commenter recommended that HCFA clarify what action by MCEs are necessary to meet the requirement that MCEs contracting under a separate child health plans have administrative and management arrangements or procedures to safeguard against fraud and abuse. The commenter asked how this requirement differ from the M+C program requirement that each M+C organization have a compliance plan. This commenter also recommended that our guidance convey that the reporting requirement in this section should only apply after the completion of a reasonable inquiry and a finding of credible evidence that a violation has occurred.

Response: We did not attempt to make the provisions of this subpart consistent

with the M+C rule. As noted previously, the Medicare program is nationally-funded and administered; while Medicaid and SCHIP are funded by a combination of State and Federal funds.

We have, however, added a provision at § 457.955(b)(2) to specify that States must ensure arrangements that prohibit MCE's from conducting any unsolicited contact with a potential enrollee for the purpose of influencing an individual to enroll in the plan. This provision is added in order to prevent past abuses in which potential enrollees were influenced to join an MCE without the benefit of adequate information and education about their options in choosing an MCE and is consistent with similar provisions in Medicaid managed care, and Medicare+Choice.

Comment: We received one comment recommending that as a condition of qualification as an MCE contractor, the MCE must allow the States to inspect and audit MCEs at any time, when there is a reasonable possibility of fraud and abuse. This condition should also apply to any provider under contract to provide SCHIP services, according to this commenter.

Response: Section 457.955(d) of the NPRM states that ''the State may inspect, evaluate, and audit MCE's at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.'' The regulation places the burden on the State to make sure that its contracts or arrangements with MCEs allow the State to comply with this section.

13. Reporting Changes in Eligibility and Redetermining Eligibility (§ 457.960)

We proposed in this section that States choosing to require that enrollees, or their representative, report changes in their circumstances during an eligibility period, the State must: (1) establish procedures to ensure that beneficiaries make timely and accurate reports of any changes in circumstances that may affect eligibility; and (2) promptly redetermine eligibility when it receives information about changes in a child's circumstances that may affect his or her eligibility.

Comment: One commenter noted that at redetermination, a child enrolled in a separate child health plan who becomes eligible for Medicaid should have a reasonable opportunity to apply and be found eligible for Medicaid without a break in coverage. The rules should specify that the child might remain enrolled in the separate child health program for up to 45 days (or longer if cause exists) while the Medicaid application is being processed in accordance with § 457.360. In addition, the rules should specify that prior to any termination of SCHIP coverage, the State should screen for potential Medicaid eligibility and facilitate enrollment.

Response: We agree with the goal of providing seamless coverage to all children eligible for Medicaid or SCHIP. See subpart C for requirements regarding screening and enrollment. These requirements apply to both eligibility determinations and redeterminations as specified at § 457.350(a).

Comment: One commenter recommended that HCFA provide guidance regarding how the redetermination process should be conducted. States should not be permitted to request a re-application or require that enrollees provide information that is not needed to complete the eligibility determination. States should also be required to give the enrollee adequate time to respond to requests for additional information. States must also be required to describe in the State plan how the child will be enrolled in Medicaid without a break in coverage.

Response: We recognize the concerns of the commenter, however, the NPRM balances the need for maintaining State flexibility while establishing an acceptable standard that will satisfy our need for accountability in the program. It would be inappropriate for us to dictate methods of redetermination or a specific redetermination process that all States must use. Rather, we are concerned that States have a redetermination process because SCHIP programs are best served by leaving the specifics of the process to each State.

14. Documentation (§ 457.965)

To ensure the integrity of the program, we proposed to require that the State include in each applicant's record certain facts that would, if necessary, support the State's determination of a child's eligibility. This documentation should be consistent with standard State laws and procedures.

We did not receive any comments on this section. Therefore, we are implementing this provision as set forth in the proposed rule.

15. Eligibility and Income Verification (Proposed § 457.970)

In this final regulation, proposed § 457.970 has been moved from subpart I to subpart C, Eligibility to become § 457.380. We have addressed comments on proposed § 457.970 in subpart C.

16. Redetermination Intervals in Cases of Suspected Enrollment Fraud (§ 457.975)

We proposed in § 457.975 that if a State suspects enrollment fraud, the State may, at its own discretion, perform eligibility redeterminations with the frequency that the State considers to be in the best interest of the SCHIP program.

Comment: One commenter noted that States should carefully consider the effect of not allowing immediate reenrollment of otherwise eligible children in SCHIP. Though the suspected fraud is very unlikely to have been conducted by the child, the commenter noted that it is the child who will suffer.

Another commenter recommended deleting this section because they believed its provisions were not only unnecessary but also might easily be abused. The commenter expressed concern that this rule could be used to justify increased scrutiny of coverage provided to racial and ethnic minorities.

Response: We appreciate this comment. We too are concerned with excluding children from coverage under SCHIP and are committed to ensure that States maintain coverage of children for as long as they are eligible and have deleted this section from the final rule.

17. Verification of Enrollment and Provider Services Received (§ 457.980)

We proposed in § 457.980 that the State must have established systems and procedures for verifying enrollee receipt of provider services. In addition, we specified that the State must establish and maintain systems to distinguish and report enrollee claims for which the State receives enhanced FMAP payments under section 2105 of the Act. We noted that these procedures would serve as a fundamental component of other program integrity activities in this proposed rule, including the fraud detection and investigation efforts discussed under §§ 457.915, 457.925, and 457.930.

Comment: Several commenters noted that the provisions of this section could be difficult to implement in managed care plans and that verification may be burdensome in a capitated system. The commenters requested that we clarify that it would be acceptable if there were a provision in the contract with the health plan to ensure provider services. One commenter expressed concern regarding external verification of provider services received in the managed care market, especially in capitation-based plans. The commenter felt that States should be able to handle

this through the normal provider evaluation and review procedures used by managed care entities.

Response: It is necessary for the effective and efficient administration of any State separate child health insurance program to monitor and verify enrollee receipt of services for which providers have billed or received payment, or that providers have contracted to furnish regardless of the method of reimbursement. Therefore, the provisions of § 457.980(a) apply to States using managed care plans as well as other systems of health insurance and care delivery. Plans participating in SCHIP are accountable to the State for providing services and care to SCHIP participants. States must ensure, when contracting with providers, that beneficiaries are receiving care to which they are entitled and for which States have provided funds.

Comment: We received a couple of comments noting that an error may have occurred in this section as medical providers bill the State but are not billed themselves. This section should read, ''The State must establish methodologies to verify whether beneficiaries have received services for which providers have billed.''

Response: We agree and have changed the text of the regulation.

18. Integrity of Professional Advice to Enrollees (§ 457.985)

To address our concern that enrollees have a right to make informed decisions about their medical care free from any form of financial incentive or conflict of interest involving their provider of care that could directly or indirectly affect the kinds of services or treatment offered, we proposed that States must guarantee in their contracts the protection described in proposed § 457.985(e). We proposed to require that States must include in their contracts for coverage and services, provisions regarding enrollee access to information related to actions that could be subject to appeal in accordance with the ''Medicare+Choice'' regulation at § 422.206, which discusses the protection of enrollee-provider communication and at § 422.208 and § 422.210(a) and (b) which discuss physician incentive limitations. We remain committed to ensuring that appropriate actions are taken to guarantee the protection of enrollee rights regarding their health care services under the Medicare, Medicaid, and SCHIP programs.

Comment: One commenter expressed its support for the requirement to provide enrollee access to information related to actions involving inappropriate arrangements that could be subject to review and appeal. One commenter noted its support for the requirement in § 457.985(e) that States prohibit gag rules and establish principles for disclosure of physician financial arrangements that could affect treatment decisions.

Response: We appreciate the support and have retained these requirements with some modification in the final rule. Section 457.985(e) has now been redesignated as § 457.985(a) and (b).

Comment: One commenter believed that HCFA does not have the authority to apply the M+C physician incentive requirements to separate child health plans.

Response: We disagree with the commenter. Under Section 2101(a) of the Act, the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. A State cannot provide child health assistance in an effective and efficient manner if it allows inappropriate physician incentive plans that have the effect of reducing or limiting health services.

Comment: Several commenters are concerned about the reference in proposed § 457.985(e)(1) prohibiting interference with medical communications between health care professionals and patients. The proposed rule refers to M+C regulations at § 422.206. The commenters would like to include only a specific reference to § 422.206(a) rather than to the whole section. Section 422.206(b) includes a ''conscience protection'' that appears to allow plans to refuse to include in their benefit package any counseling or referral service to which the plan asserts a moral or religious objection. Some commenters noted that there is an explicit statutory provision in the M+C portion of the Balanced Budget Act that deals with conscience-based refusals to provide services and the M+C regulatory provision parallels the statute, but there is no similar statutory requirement in SCHIP. The commenters noted that the regulation also should not reference § 422.206(b) in order to preserve access to health care services and information about them. According to this commenter, a health plan that refuses to provide counseling or referral services impairs access to those services, and typically the services most at risk are reproductive health services provided to women. The commenters further argued that this provision conflicts with the CBRR goal of open communication between health care professionals and patients in all cases, without qualification or exception.

Response: We agree that the regulation should reference only § 422.206(a). The remainder of § 422.206 contains requirements for reporting to HCFA sanctions for Medicare+Choice organizations that are not applicable in a separate child health program. However, not all providers are required to offer all services in the SCHIP benefit packages. If a State contracts with providers that have a moral or religious objection to providing particular services, the State retains the responsibility to assure that enrollees are informed of and have access to all services included as a part of the benefit package consistent with § 457.495.

Comment: One commenter noted that the preamble to the proposed rule (p. 60928), which cross-references § 422.208 of the M+C regulations, appears to apply the physician incentive requirements to separate child health programs. However, § 457.995(d) and § 457.985(e) appear to apply only the disclosure requirements, not the substantial financial risk requirements, to the SCHIP program. This commenter recommended that HCFA clarify this requirement.

Response: A State must guarantee compliance with all of the provisions of § 422.208 (relating to limitations on physician incentive plans) and § 422.210 (relating to disclosure of physician incentive plans) of this chapter as stated in § 457.985.

Comment: One commenter recommended that States should be allowed to provide protections against the gag rule and physician incentives in accordance with their own State law.

Response: While we appreciate State efforts to prohibit gag rules and inappropriate physician incentive plans, it is necessary to require compliance with § 422.208 and § 422.210 of this chapter to ensure nationwide protection of enrollees in separate child health programs consistent with the CBRR.

I. Subpart J—Allowable Waivers: General Provisions

1. Basis, Scope, and Applicability (§ 457.1000)

This subpart interprets and implements the requirements for a waiver under section 2105(c)(2)(B) to permit a State to exceed the 10 percent limit on expenditures as specified in section 2105(c)(2)(A), and for a waiver to permit the purchase of family coverage under section 2105(c)(3) of the Act. This subpart applies to a separate child health program and to a Medicaid expansion program only to the extent

that the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system.

Comment: One commenter noted that there appears to be a word missing in § 457.1000(c). The sentence ends with ''seeks a waiver of limitations such claims in light of a community-based health delivery system.'' The commenter believes that ''on'' should be inserted after ''limitations,'' although the meaning is still unclear.

Response: We have corrected § 457.1000(c), as suggested by the commenter, by adding the word ''on''. We have also edited the sentence for clarity. The first part of the sentence now indicates that the requirements of this subpart apply to a separate child health program. The second part of the sentence clarifies that the requirements of this subpart also apply for States that operate Medicaid expansion programs if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for cost-effective coverage through a community-based health delivery system.

Comment: One commenter suggested that the same time frames for HCFA approval that are proposed for State plan and State plan amendment approvals be included for waivers.

Response: We have amended the regulation text by adding a new § 457.1003 to clarify that we will review the waivers under this subpart as State plan amendments under the time frames as specified in § 457.160. In practice, State proposals for these waivers have been reviewed as part of the initial State plan or amendment and within the 90-day review period permitted under statute. These waivers must be reflected in the State plan and updated accordingly. It should be noted that the 90-day time frame for review does not apply to HCFA review of section 1115 demonstration proposals under this title.

2. Waiver for Cost-Effective Coverage Through a Community-Based Health Delivery System (§ 457.1005)

Section § 457.1005 interprets and implements section 2105(c)(2)(B) of the Act regarding waivers authorized for cost-effective alternatives. In § 457.1005, we proposed requirements for a State wishing to obtain a waiver of the 10 percent limit on expenditures not used for child health assistance in the form of health benefits coverage that meets the requirements of § 457.410. This section also clarifies the extent to which the State will be allowed to exceed the 10 percent limitation on such expenditures in order to provide child health assistance to targeted low-income children under the State plan through cost-effective, community-based health care delivery systems.

To receive payment for cost-effective coverage through a community-based health delivery system under an approved waiver, we proposed that the State must demonstrate that—

- Such coverage meets the coverage requirements of section 2103 of the Act and subpart D of this part; and
- The cost of coverage through the community-based health care delivery system, on an average per child basis, does not exceed the cost of coverage that would otherwise be provided under the State plan.

We noted in the preamble to the proposed rule that a State may define a community-based delivery system to meet the specific needs and resources of a community, as long as it ensures that its community-based delivery system (either through direct provision or referral) can provide all appropriate services to targeted low-income children in accordance with section 2103 of the Act. We also proposed that all community-based providers must comply with all other title XXI provisions.

We proposed that an approved waiver will remain in effect for two years and that a State may reapply three months before the end of the two-year period. We also proposed that, notwithstanding the 10 percent limit on expenditures described in § 457.618, if the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the cost savings for—

- Child health assistance to targeted low-income children and other low-income children other than the required health benefits coverage, health services initiatives, and outreach; or
- Any reasonable costs necessary to administer the State Children's Health Insurance Program.

Comment: One commenter suggested that HCFA adopt the definition of ''health services initiatives'' set forth in the August 6, 1998 letter to State Health Officials. In the letter, the term is defined as ''activities that protect the public health, protect the health of individuals or improve or promote a State's capacity to deliver public health services and/or strengthens resources needed to meet public health goals.'' In addition, the commenter suggested that the preamble make clear that all immigrant children, regardless of their status or date of entry, can participate in, and benefit from, health services initiatives.

Response: We agree with the commenter. We have added the definition of ''health services initiatives'' as set forth in the August 6, 1998 letter to the definitions section of the regulations text at § 457.10. We note that this definition of health services initiatives includes ''other low-income children,'' which can include immigrant children, regardless of their status or date of entry, and children who are eligible for Medicaid but not enrolled. As specified in our January, 14, 1998 letter to State Health Officials, health services initiatives may benefit the health of all low-income children, including but not limited to children eligible to receive services under title XXI. Therefore, health services initiatives such as health education activities, school health programs and direct services (such as newborn hearing and lead testing programs), could be targeted to low-income, immigrant communities.

Comment: One commenter proposed that States be permitted to use title XXI funds under this waiver to pay for primary care services provided by community-based providers to children who are not targeted low-income children eligible for the State's title XXI program, in order to increase access to medically necessary primary care for uninsured SCHIP-eligible children who are not yet enrolled in the State's title XXI program.

Response: States may provide primary care services to children who are not targeted low-income children through a ''health services initiative under the plan for improving the health of children (including targeted low-income children and other low-income children).'' These expenditures would be subject to the 10 percent limit as specified in section 2105(c)(2)(A), except to the extent that the State pays for these services through the use of savings from the waiver for a cost-effective alternative delivery system. In this case, the State could use the savings for primary care services for unenrolled low-income children and those expenditures would not be subject to the 10 percent cap.

Another option for States to consider is using this waiver in conjunction with presumptive eligibility (provisional enrollment). The costs associated with a period of provisional enrollment are benefit costs when the child subsequently is determined eligible for either Medicaid or a separate child health program. However, the costs associated with a period of provisional enrollment for a child who is later

determined ineligible for either Medicaid or a separate child health program are costs that are normally subject to the 10 percent limitation. When services are provided during a period of provisional enrollment to a child who is low-income and whom the State later determines to be ineligible for either Medicaid or a separate child health program, the costs of providing benefits to these low-income, ineligible children could be funded through the use of the waiver for a cost effective alternative delivery system. Again, the benefits provided would have to meet all the requirements of § 457.410.

Comment: One commenter suggested allowing States to set aside a portion of their title XXI allotment for a community-based provider program. The commenter noted 90 percent of the set-aside funds would pay for services to SCHIP eligible children and 10 percent of the set-aside funds would pay for administration.

Response: The Act does not dictate how States set their budgets generally or set budget priorities relating to community-based waiver programs. Section 2105(a) authorizes the Secretary to pay a State from its allotment based upon actual expenditures for child health assistance. The State might be able to make expenditures according to the proportions described above. However, as specified in section 2105(c)(2)(A), the amount of administrative expenditures that a State can claim is directly tied to the amount of expenditures they claim for child health assistance.

Comment: One commenter believed that the language in section § 457.1005(b)(2) is unclear and asked whether the ''State plan'' referred to is the Medicaid State plan or the SCHIP State plan.

Response: The waiver described in proposed § 457.1005(b)(2) is a program waiver under title XXI and, therefore, the State plan referred to in this section is the title XXI State plan, as defined in § 457.10.

Comment: One commenter recommended amending § 457.1005(b)(1) regarding requirements for obtaining a waiver to incorporate a reference to the cost-sharing protections in subpart E and the various beneficiary protections provided in other subparts of the rule and summarized in § 457.995. The commenter was concerned that children receiving care in a community-based health delivery system would not benefit from the consumer protections provided in the regulation, and that States should be not permitted to utilize this waiver as a means of circumventing the protections that are afforded to other SCHIP applicants and enrollees.

Response: As proposed, the regulation text at § 457.1005(b) required States obtaining a waiver for cost-effective coverage through a community-based health delivery system to demonstrate that (1) the coverage meets the coverage requirements of section 2103 of the Act and subpart D of this part; and (2) the cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan. In the preamble to the proposed rule, we stated that, for the purposes of a waiver, all participating community-based providers must comply with all other title XXI provisions. On further consideration, we have clarified the policy under the final regulation. Section 457.1005(b)) now requires that, in providing child health assistance through the waiver, the coverage must meet all the requirements of this part, including subparts D and E. Therefore, the final regulation clarifies that all title XXI protections will apply under a waiver for a community-based delivery system in order to assure that all children receive the same protections regardless of where they receive services.

Comment: One commenter believes that HCFA's example of coverage for a special group, such as children who are homeless or who have special health care needs, does not consider that the care for these children may cost more than the care for the average child. The commenter recommended that HCFA reconsider § 457.1005 and provide options for States to proceed with caring for children with special needs in a manner that allows payment above the cost of providing coverage to the ''average'' child.

Response: Section 2105(c)(2)(B)(ii) of the Act specifies that the cost of coverage through the community-based health care delivery system, on an average per child basis, may not exceed the cost of coverage that would otherwise be provided under the State plan. In an August 6, 1998 letter to State Health Officials, we stated that the amount paid to the community-based delivery system on a Federal fiscal year, per child basis must not be greater than the amount that would otherwise have been paid for that child to receive coverage under title XXI. For example, if the amounts that the State pays health plans under the State plan reflect the risk entailed in providing care to special needs children (because the State risk adjusts its capitation payments, or because the State provides services to these children on a fee-for-service basis), these above-average costs for the special needs children in fact, will be reflected in the cost-effectiveness calculation. Therefore, the cost-effectiveness calculation required under § 457.1005(b)(2) does not preclude the State from adjusting its payments for the care of special needs children to provide for higher payment for such care.

Comment: One commenter applauded HCFA's interpretation of waivers as stated in the proposed rule and agreed with the statement that the purpose of this waiver was to increase health services and not to increase funds for administration.

Response: The preamble of the proposed rule set forth our belief that Congress did not intend that the waiver be used primarily to allow for more administrative spending or spending on outreach services under section 2105(a)(2). While we appreciate the support of the commenter, we also point out that States do retain flexibility regarding the use of any savings obtained as a result of this waiver pursuant to § 457.1005(d).

Comment: A number of commenters recommended that approved waivers should initially remain in effect for three years, to coincide with the time frames at section 2104(e) of the Act for spending the funding allotment for each year, and to provide time to evaluate the waiver's impact and to demonstrate cost-effectiveness. Following the initial approval period, one commenter recommended that the duration be five years, in keeping with the typical duration of 1115 waivers.

Response: We agree with the commenters' suggestion that a 3-year approval period would coincide with statutory time frames for the expenditure of allotments and provide a more adequate period of time in which to determine cost-effectiveness. Therefore, we have revised § 457.1005(c) to provide that the duration of time for which waivers for cost-effective coverage through a community-based health delivery system are approved is three years. We will continue to determine cost-effectiveness upon application and renewal for the waiver. However, we have not accepted the recommendation to extend the waiver period to five years because it is important to assess the cost-effectiveness of community-based health delivery systems on a more frequent basis. We have also revised the regulation at § 457.1005 to indicate that a State may reapply for approval 90 days before the end of the three year period for consistency with the 90 day review period that apply to State plan amendments.

3. Waiver for Purchase of Family Coverage (§ 457.1010)

We proposed that a State must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for adult family members in addition to targeted low-income children. We proposed at § 457.1010 that a waiver for family coverage will be approved by the Secretary if—

- Purchase of family coverage is cost-effective under the standards described in § 457.1015 of this subpart;
- The State does not purchase such coverage if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage; and
- The coverage for the child otherwise meets the requirements of this part.

We requested comments on whether the benefits specified in title XXI also apply to adults covered by a family coverage waiver. For example, if a State offers ''wraparound coverage'' to bring an employer's benefits up to the title XXI standards, we solicited comments as to whether the State should be required to offer this additional coverage to adults under the family waiver.

We noted that there is no statutory definition of family coverage for the purposes of this subpart and we solicited input from commenters on the definition of ''family'' for purposes of this subpart.

Comment: Many commenters questioned whether States covering parents of SCHIP children through a family coverage waiver must provide the benefits specified in title XXI to the family members who would not otherwise be eligible for SCHIP coverage. These commenters asserted that this decision should be left to State discretion. Commenters did not believe that there is any statutory basis for such a rule. Commenters also indicated that such a requirement would dramatically restrict States' ability to achieve cost-effectiveness in family coverage and would result in a reduction in the number of children that could be insured through the program. Commenters also noted that such a requirement could further complicate the States' administration of benefit and/or cost-sharing upgrades for premium assistance programs because of the difficulty in administering benefit upgrades.

Response: We appreciate the commenters' consideration of this issue, but disagree with the recommendation and rationale because we do not believe it gives weight to the congressional interest in a standard minimum benefit package for all covered individuals. Congress clearly intended that title XXI funds be used to provide a comprehensive benefit package meeting the requirements of section 2103. Children's benefits under a premium assistance program must meet requirements in section 2103, and benefits offered under group health plans typically do not differ for adults and children. In addition, title XXI provides considerable flexibility for States to choose a benchmark package against which they can compare the benefits offered under a group health plan. Therefore, we have decided to require that any health benefits coverage provided under a family coverage waiver must comply with the benefit requirements of § 457.410 and have revised the language at § 457.1010(c) to reflect this change.

Section 2105(c)(3)(A) provides the authority for this policy because it requires that the purchase of family coverage must be cost-effective relative to the amounts that the State would have paid to obtain ''comparable coverage'' for only the targeted low-income children involved. Therefore, this provision clearly contemplates that the coverage offered to non-eligible family members under a family coverage waiver would be comparable to the coverage that would be offered to targeted low-income children. We believe that requiring the family coverage to meet title XXI standards best assures this comparability and is most consistent with the intended use of title XXI funds. However, we have interpreted the statute's use of the term ''comparable'' to permit the coverage of non-SCHIP eligible family members to be based on a different title XXI benchmark than the targeted low-income children's coverage.

While we recognize the cost of family coverage will increase if the State provides wrap-around coverage to adults in addition to the benefits provided by the group health plan, the degree of cost increase is unclear. For example, when the ''wrap-around'' supplemental coverage provided by the State to meet the section 2103 requirements is coverage only for well-baby and well-child services, there would be no additional costs to provide coverage that meets the requirements of section 2103 for adults, because this ''wrap-around'' coverage is not relevant for adults.

Comment: One commenter stated that it is not clear what would be included in a benefits upgrade for adults. For instance, the commenter questioned if there would need to be a prohibition on cost sharing for adult preventive care visits and services to reflect the statutory prohibitions on copayments or cost sharing for well-baby or well-child care. If this were the case, the commenter indicated that the cost of implementing such a provision would obviously be significant.

Response: While States must ensure that health benefits coverage provided to all family members, including adults, meets the requirements of section 2103, not all benefits are relevant to adult enrollees. For instance, while the statute requires the provision of well-baby and well-child care and prohibits cost sharing for these services, these services are not applicable or available to adults. Therefore, States would not be required to provide coverage to adults for these services, and the specific cost-sharing restrictions applicable to these services also would not apply to adults. However, general cost-sharing limitations do apply to covered services for adults and children under the family coverage waiver. For example, some States have expressed interest in providing coverage to families above 150% of the FPL and, for this income level, the cumulative cost-sharing maximum of 5% of family income would apply.

Comment: One commenter suggested that HCFA clarify how wrap-around coverage programs could be designed to make family coverage waivers viable, cost effective and simple to administer for group health plans.

Response: We recognize the challenges faced by States in establishing and operating premium assistance programs. The challenges result from the fact that title XXI primarily was designed for targeted low-income children receiving health benefits coverage through programs operated directly by the State, rather than for families receiving health benefits coverage through group health plans. Nonetheless, it is possible to address these challenges. For example, some States are structuring their premium assistance programs to permit direct billing from providers to the State for services or cost sharing that is not covered by the group health plan. In addition, there is flexibility for States to select from among a variety of benchmark benefit packages, and States should carefully consider this flexibility when designing premium assistance programs. We will continue to share new approaches with States as they are developed.

Comment: Commenters encouraged the use of ''family'' as defined by States, employers, and/or the individual contracting health insurance plans. One

commenter believed that States and the Federal government do not need to, and in fact cannot, develop a standard definition. Commenters noted that family coverage waivers will likely be provided through employer-sponsored plans, where the issue of which family members may be included under the employer plan is regulated by contract with insurers and State insurance law. One commenter is planning to submit a request to subsidize employer-sponsored insurance that involves several premium tiers based on which family members are covered and suggests that the definition of ''family'' include the employee, spouse and children, or employee, and children depending on family composition and the coverage tier selected. Other commenters felt that HCFA should not create a definition of ''family,'' because such a definition could restrict the ability of group health plans or health insurance issuers from defining what constitutes family coverage. One commenter also noted that a more flexible approach would ease administration and maximize the availability of the family coverage waiver option. Another commenter suggested that the definition be left to State discretion and that once HCFA reviews a wide range of proposals, it can revise the regulations to include a definition if necessary.

Response: We have not defined ''family'' for the purposes of this regulation in general and, after considering these comments, we agree with the commenters that one standard definition of ''family'' could unnecessarily restrict States' ability to utilize a family coverage waiver. Therefore, the decision regarding how to define ''family'' is left to States' discretion.

Comment: One commenter urged that the definition of ''family'' include adult pregnant women without other family members. The commenter believes that this expansion of the definition is integral to ensuring that all pregnant women have access in their community to readily available and regularly scheduled obstetric care, beginning in early pregnancy and continuing through the postpartum period.

Response: While we support States' efforts to cover pregnant women, title XXI does not support an expansion of coverage to include pregnant women who are not family members of SCHIP-eligible children. Section 2105(c)(3) permits payment to a State for family coverage under ''a group health plan or health insurance coverage that includes coverage of targeted low-income children.'' The statute requires the State to compare the cost of coverage ''only of the targeted low-income children involved'' with the cost of coverage for the family. A State wishing to cover a pregnant woman who is not a family member of a targeted low-income child would not be able to perform the required cost-effectiveness test. Therefore, a pregnant woman can be covered through a family coverage waiver only to the extent that a targeted low-income child in her family is eligible for SCHIP coverage.

Comment: A commenter noted that in the preamble to the proposed rule, we stated that States must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for adult family members in addition to targeted low-income children. We also noted that States may purchase coverage for children through premium assistance programs using employer-sponsored insurance without a family coverage waiver when the costs of such children are identifiable. One commenter was concerned that the premium tier structures available to most employers do not permit the costs of children to be identified. The commenter noted that employers offer only two coverage tiers, employee-only and family coverage, which does not permit this kind of determination, because other family members, such as spouses, also may be covered under the family coverage tier. The commenter asserted that the options permitted in the proposed rule for determining the cost of children under employer-sponsored coverage will mean that most States seeking to cover a significant number of uninsured children under a premium assistance program will need to obtain a family coverage waiver.

Because States may wish to utilize employer-sponsored insurance without subsidizing coverage for the adults in the family, the commenter suggested an alternative method for determining the cost of targeted low-income children covered through employer-sponsored coverage. The commenter proposed that States be permitted to pay a proportion or percentage of the cost of employer-sponsored family coverage without obtaining a family coverage waiver, as long as the portion the State pays is based on a reasonable actuarial estimate of what proportion of the cost of family coverage is attributable to the children, and as long as it meets the cost-effectiveness test.

The commenter suggested that the actuarial determination of the proportion to be paid could be made once a year, based on typical group health coverage plan available in the State, and the percentage could then be applied to the actual premium for family coverage under the specific employer's plan.

Response: We have reconsidered the requirement in the preamble to the NPRM that a family coverage waiver is needed when any title XXI funds are used to provide coverage for adult members of the family. We will not require States to obtain a family coverage waiver in cases where the employee's premium is not subsidized and there is no intention on the part of the State to cover family members other than targeted low-income children. We also agree that the suggestion offered by the commenter appears to offer another possible option for States to identify the costs of enrolling only the eligible child or children in the family into a premium assistance program, and thereby enroll the children without obtaining a family coverage waiver. As described in the proposed rule, child-only costs can be identified when a State is purchasing a child-only policy, or in markets in which carriers offer policies with a sufficient number of premium tiers to identify the costs of the SCHIP-eligible child or children. Such tiers might include an employee-only premium tier, and an employee-plus-children premium tier, such that the former can be subtracted from the latter to determine the cost of the child or children. However, as the commenter points out, these premium tier structures may not be common or uniformly available in most States.

In a more typical group health insurance market that offers coverage tiers for employee-only or family coverage, the employee contribution amounts for employee-only and for family coverage are known. The difference between the two is the cost for dependent coverage. Again, if title XXI only subsidizes the difference between employee-only and family coverage, a family coverage waiver is not needed as long as there is no intention to cover non-SCHIP eligible family members. However, as an alternate approach, the State could decide to allocate the cost for dependent coverage between the spouse and children on a reasonable actuarial basis and a family coverage waiver would not be required if the State then pays only that portion allocated to coverage of the targeted low-income child or children. An actuary familiar with the State's group health market could produce an estimate of the cost of one adult relative to the cost for one child under a group health plan. This ratio could then be applied to the family composition to determine what portion of the premium pays for the spouse's coverage and what

portion pays for the children's coverage. The State would then pay only that portion attributable to the child or children.

We note, however, that this method may be difficult for States to implement in practice given the need to obtain sufficient data to perform the necessary actuarial estimates. In addition, the subsidy amount determined under this method does not cover the family's full premium cost, which may discourage some families from enrolling. For these reasons, calculating the difference between employee-only and family coverage costs may be a preferable alternative to obtaining actuarial estimates of the costs of only the targeted low-income children for many States. We also note that when a State subsidizes family coverage, but is covering only targeted low-income children (that is, no payment is being made for the employee portion of the premium, and there is no intention to cover family members other than the targeted low-income children and the costs do not exceed the cost-effective amount), the requirements of this part apply to only the targeted low-income children. We reiterate that family coverage waivers are subject to the same 90-day review period as any other title XXI State plan amendment and need not be unduly burdensome to obtain.

In order to assist States in designing premium assistance programs to cover only targeted low-income children using employer sponsored insurance, we will work with States on their specific proposals to develop mechanisms for identifying the cost of covering the targeted low-income children using reasonable methods, for the purposes of determining cost-effectiveness.

Comment: Several commenters indicated that family coverage waivers will be challenging for States to implement. One commenter expressed concern that the standards for family coverage waivers are impossible to meet and should be made easier to accomplish via a statutory change. Another commenter supported States' interest in developing programs to provide coverage to whole families and urged HCFA to provide more support and technical assistance and to grant more family coverage waivers.

Response: We are committed to sharing best practices and providing guidance to States designing and implementing family coverage waivers and premium assistance programs. To date, three States have received approval for family coverage waivers. As States gain more experience with their premium assistance programs and their family coverage waivers, we will work to disseminate information about the challenges and successes of these programs.

Comment: A number of commenters were concerned that the proposed regulations are too restrictive regarding when a family coverage waiver is needed. Some noted that, while Congress intended to expand coverage to children, recent research suggests that expanding parents' access to health care coverage also increases children's enrollment, as parents are more likely to apply for and enroll their children in a health insurance program if the whole family is covered by the same plan. They encouraged HCFA to permit States to experiment with both title XIX and title XXI funds to cover parents as an effective strategy to increase enrollment levels of children. They also noted that most States have not spent a significant portion of their title XXI allotments, and may be able to expand coverage further if more flexibility is granted for enrolling parents under title XXI.

Response: We recognize the link between children's enrollment and parental access to SCHIP coverage. We have provided flexibility on this as permitted by the statute. Section 2105(c)(3) sets forth certain requirements relating the coverage of families through a family coverage waiver, and § 457.1010 of this regulation implements that section. However, we will continue to work with States that wish to design and implement programs under a family coverage waiver to help facilitate the enrollment of parents of SCHIP-eligible children in a manner consistent with title XXI.

Comment: One commenter stated that the proposed rule indicates that the community-based waiver applies to Medicaid expansion programs, but the family coverage waiver does not. It is the commenter's opinion that family coverage waivers should be allowed in Medicaid expansion programs.

Response: Family coverage waivers are required whenever States are funding coverage for any non-SCHIP eligible family members with title XXI funds under a separate child health program. Under Medicaid, States are able to purchase employer-sponsored coverage for regular Medicaid and Medicaid expansion enrollees under section 1906 of the Act, which permits States to pay premiums, deductibles, and coinsurance on behalf of Medicaid beneficiaries eligible for enrollment in employer-based group health plans when it is cost-effective to do so. The only exception to this distinction between family coverage in Medicaid expansions and separate child health programs is within the context of our authority under section 1115 of the Act. Section 1115 demonstrations are not subject to regular Medicaid rules when those rules are modified under the Secretary's authority to grant certain waivers, to provide federal funds for costs that would not otherwise be matchable and to impose special terms and conditions for such demonstrations. In all cases, we are committed to working with States interested in using either funding source, either separately, or in conjunction with each other. As mentioned previously, a family coverage waiver is not needed when the coverage of adult family members is only incidental.

Comment: Several commenters supported coverage of adult family members under family coverage waivers. One commenter supported State flexibility to cover family members but believed that before granting a family coverage waiver, HCFA should ensure that States have utilized their options for expanding health coverage to lower-income adults in non-title XXI funded programs. The commenter notes that HCFA and ACF, in their publication ''Supporting Families in Transition,'' indicated that before expanding coverage under title XXI, States will need to implement a Medicaid expansion under section 1931 of the Act to avoid an anomalous result in which higher income families are covered under SCHIP, while parents of lower-income children lack coverage. Another commenter suggested that HCFA encourage States to apply for Medicaid waivers to expand insurance coverage to adult pregnant women and to facilitate the more rapid enrollment of their infants.

Response: We agree that States' ability to use Medicaid rules to expand coverage to other family members is an important option, and we have been working with States to clarify the flexibility that exists to do this. Under Medicaid, States may purchase family coverage through employer-sponsored coverage under section 1906 of the Act, which permits States to pay enrollee premiums in employers' group health plans when it is cost-effective to obtain coverage for Medicaid-eligible individuals (deductibles, coinsurance and other cost sharing for ineligible family members may not be paid as medical assistance).

In addition, States may submit proposals for demonstrations under section 1115 of the Act to expand coverage to parents of children covered under SCHIP. HCFA released guidance on July 31, 2000 regarding parameters for consideration of such proposals.

Comment: Several commenters proposed that States should meet prerequisites before receiving approval for family coverage waivers. Some commenters proposed that States must eliminate the asset test under Medicaid and SCHIP and adopt simplified application, enrollment and redetermination procedures for children. Other commenters suggested that States should expand coverage for children with family income up to at least 200 percent of FPL (or 50 percentage points above the State's Medicaid applicable income threshold) throughout the areas of the State; ensure that all eligible children are promptly enrolled into a State's title XXI program without being subject to a waiting list; and, if the State operates a separate child health program, adopt a joint Medicaid/SCHIP application and assure that the same or directly comparable application, enrollment and redetermination procedure is used for children under Medicaid and the separate State program. Another commenter proposed that States should first be required to ensure that there is no lessening of SCHIP benefits or increase in cost sharing associated with a waiver using this method of calculating cost-effectiveness.

Response: While we support all of these goals, title XXI provides no statutory authority for requiring States to meet these goals prior to the approval of a family coverage waiver. We have been working with States to clarify Federal law and to provide technical assistance regarding the implementation of such policies in order to support States' efforts to undertake activities that will expand and simplify eligibility, increase the number of children who enroll in States' programs, and to make the enrollment and redetermination processes less burdensome on States, applicants and enrollees.

4. Cost-Effectiveness (§ 457.1015)

This section defines cost-effectiveness and describes the procedures for establishing cost-effectiveness for the purpose of a family coverage waiver.

We proposed that cost-effectiveness means that the cost of purchasing family coverage under a group health plan or health insurance coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining such coverage only for the eligible targeted low-income child or children involved. Stated more simply, cost-effectiveness for the family coverage waiver means that the cost of providing family coverage (including coverage for the parents) is equal to or less than the cost of covering only the SCHIP-eligible children.

We proposed that a State may demonstrate cost-effectiveness by comparing the cost of family coverage that meets the requirements of §§ 457.1010 and 457.1015 of this subpart, to the cost of coverage only for the targeted low-income child or children under the health benefits packages offered by the State under the State plan for which the child is eligible. Alternatively, we proposed that the State may compare the cost of family coverage to any child-only health benefits package that meets the requirements of § 457.410, even if the State does not offer it under the State plan. We stated that we would examine other alternatives and we invited comment on additional methods for demonstrating cost-effectiveness. We set forth an illustration of cost comparison in the proposed rule.

We proposed that the State may demonstrate the cost-effectiveness of family coverage by applying the cost of family coverage for individual families assessed on a case-by-case basis, or for family coverage in the aggregate. We noted that if a State chooses to apply the cost-effectiveness test on a case-by-case basis, the State must compare the cost of coverage for each family to the cost of coverage for only the child or children in the family under SCHIP. We further explained that if a State chooses to apply the cost-effectiveness test in the aggregate, the State must provide an estimate of the projected total costs of the family coverage program compared to the cost the State would have incurred for covering just the children in those families under the publicly-available SCHIP plan. If the State chooses to assess the cost of family coverage in the aggregate, we also proposed that, on an annual basis, the State must compare the total actual cost of covering all families for whom the State has purchased family coverage to the cost the State would have incurred covering just the children in those families under the publicly-available SCHIP plan. If the aggregate cost of family coverage was less than the cost to cover the children under the publicly available program, then the family coverage would be considered cost-effective. If the State determines through its annual assessment of cost-effectiveness that family coverage is not cost-effective in the aggregate, we proposed that the State must begin to apply the cost-effectiveness test on a case-by-case basis.

Comment: Many commenters indicated that, given the two-year length of approved waivers, the cost-effectiveness assessment should be done for the life of the waiver.

Response: Section 457.1015 addresses cost-effectiveness for family coverage waivers only, and does not address the cost-effectiveness of waivers for a community-based delivery system. Cost-effectiveness of waivers for a community-based delivery system is determined each time a State applies for or renews its waiver. As stated earlier, we have agreed to extend the period of time for which these waivers are approved from two years to three years.

Family coverage waivers are part of the State plan and are approved for an open-ended period of time after an initial demonstration of cost-effectiveness. However, we will continue to require a State to demonstrate the cost-effectiveness of the family coverage waiver on an annual basis, whether done on a case-by case or aggregate basis, consistent with § 457.1015(d). Because we have little information about the costs associated with family coverage waivers, we want to assure that States' premium assistance programs are being administered in the most cost-effective manner possible, and to be able to obtain results so as to share best practices with other States.

We have reconsidered the proposed provision that would have permitted States to conduct its cost comparison against any child-only policy even if it is not offered under the State plan. The revised language requires that the cost comparison be done relative to the State's actual costs under the State plan in order to assure coverage is provided in the most cost effective manner.

Comment: Several commenters wrote to express support of the rule as written with regard to the cost-effectiveness test. One commenter supported permitting States to perform retrospective cost-effectiveness evaluations but suggested that the cost-effectiveness comparisons should be clarified. Specifically, the commenter indicated that the first example (64 FR 60932) omits any costs for the supplemental coverage that will likely need to be provided and included in the cost-effectiveness test because employer plans may not always cover some services that must be covered under title XXI or exempt well-baby and well-child care from cost sharing.

Response: Although the example in the NPRM did not include the cost of supplemental benefits, the cost of supplemental benefits must be reflected in States' cost-effectiveness analyses. For example, assume the cost to cover two targeted low-income children under the State plan is $200 per month and the cost to cover the family in the employer

plan is $120 per month. The State also provides supplemental coverage for benefits and cost sharing that costs $40 per month per family. This $40 would be added to the $120 for a total of $160 which is still cost-effective in comparison to the $200 that would have been paid under the State plan for only the children. We have also revised the provision at § 457.1015 to indicate that cost-effective means that the cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the plan only for the targeted low-income children involved. We have eliminated the specific reference to the cost paid under a group health plan or health insurance coverage in order to clarify that all costs associated with providing family coverage, including any supplemental coverage, must be considered when determining cost-effectiveness.

Comment: Some commenters believed that because the Department has not developed standards or guidance regarding budget neutrality, State determinations of cost-effectiveness must be accepted and reasonable waivers and family coverage variances should be approved in a timely fashion.

Response: We have clarified the requirements for determining cost-effectiveness under the waiver for cost-effective coverage through a community based delivery system and the waiver for family coverage in both the NPRM and this final rule. Budget neutrality is a relevant consideration with respect to section 1115 demonstration projects, but not with respect to waivers discussed under subpart J. We are committed to working with States interested in designing and implementing the waivers under subpart J to find the best way possible to comply with these regulations and effectively implement their programs.

J. Subpart K—Applicant and Enrollee Protections

In response to public comment, in this final rule, we relocated certain provisions involving applicant and enrollee protections to this new subpart K, ''Applicant and Enrollee Protections.'' Specifically, we moved to this subpart certain provisions of proposed § 457.902, which set forth definitions applicable to enrollee protections, proposed § 457.985, which set forth requirements relating to grievances and appeals, and proposed § 457.990, which set forth requirements for privacy protections. Public comments received on the relocated proposed provisions and changes made to them are discussed below.

To eliminate inconsistency and potential confusion, and in response to public comment, we decided to remove from the regulation text proposed at § 457.995, which provided an overview of the enrollee rights provided in this part. Instead, we provide an overview of the enrollee protections contained throughout the part in the preamble to this final regulation. We respond below to the general comments on proposed § 457.995, as well as to any general comments relating to the Consumer Bill of Rights and Responsibilities (CBRR). To the extent that a comment on proposed § 457.995 relates to a specific enrollee protection provision cross-referenced in the proposed overview section, but located elsewhere than subpart I of the proposed regulation, we responded to that comment earlier in this final rule in conjunction with comments and responses relating to that specific provision.

The most significant changes reflected in this subpart were made to the proposed ''grievance and appeal'' provisions at § 457.985. Given the lack of clarity regarding the use of the terms ''grievances'' and ''appeals,'' as noted by some of the commenters, we removed these terms from the final regulation. We opted instead, as we make clear in our responses to comments, to refer to the procedural protections required under this regulation as the ''review process.'' We also note that in clarifying the scope and type of matters subject to review, we narrowed the range of matters subject to review from those defined in the proposed regulation. The minimum requirements for a review process identified in this regulation will apply only to separate child health programs, and States retain a significant amount of flexibility in designing their processes.

In this final regulation, a State is required to include in its State plan a description of the State's review processes and, pursuant to § 457.120, to offer the public the opportunity to provide input into the design of the review process. We also clarify that matters involving eligibility and enrollment, on the one hand, and health services, on the other, are subject to somewhat different review requirements. Core elements for a review process applicable to reviews of both types of matters; States may adopt their own policies and procedures for reviews that address these core elements. Such policies and procedures must ensure that—(a) Reviews are conducted by an impartial person or entity in accordance with § 457.1150; (b) review decisions are timely in accordance with § 457.1160; (c) review decisions are written; and (d) applicants and enrollees have an opportunity to—(1) represent themselves or have representatives of their choosing in the review process; (2) timely review their files and other applicable information relevant to the review of the decision; (3) fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and (4) receive continued enrollment in accordance with § 457.1170. Under the provisions of this final rule, a State could use State employees, including State hearing officers, or contractors to conduct the reviews, reviews could be conducted in person, by phone or based on the relevant documents, and a State could choose to use the same general process or different processes for reviews of eligibility and enrollment decisions and health services decisions.

With respect to enrollment matters, States must provide an applicant or enrollee with an opportunity for review of: (1) A denial of eligibility; (2) a failure to make a timely determination of eligibility; or (3) a suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. States are not required to provide an opportunity for review of these matters if the sole basis for the decision is a change in the State plan or a change in Federal or State law (requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances). For example, if a State amends its plan to eliminate all speech therapy services, a review would not be required if an individual appeals the denial of speech therapy. The final rules also establish that States must complete the review within a reasonable amount of time and that the process must be conducted in an impartial manner by a person or entity (*e.g.* a contractor) who has not been directly involved with the matter under review. For matters related to termination or suspension of enrollment, including a disenrollment for failure to pay cost sharing, the rules require that a State ensure the opportunity for continued enrollment pending the completion of the review.

As to adverse health services matters, a State must provide access to external review of decisions to delay, deny, reduce, suspend, or terminate services, in whole or in part, including a

determination about the type or level of services; or of a failure to approve, furnish, or provide payment for health services in a timely manner. The external review must be conducted in an impartial and independent manner, by the State or a contractor other than the contractor responsible for the matter subject to external review. All reviews must be completed in accordance with the medical needs of the patient. The rules establish an overall 90-day time frame for external review, including any internal review that may be available. The rules also establish a 72-hour expedited time frame in the case where operating under the standard time frames could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. In such situations, the enrollee has access to internal and external review, then each level of review may take no more than 72 hours. If the enrollee's physician determines the review should be expedited then it must be conducted accordingly, both for internal (if applicable) and external review.

In addition, we clarify the notice requirements at § 457.1180, and require a State in § 457.110(b)(6) to make available to potential applicants, and provide to applicants and enrollees information about the review processes that are available to applicants and enrollees. The rules also require that States ensure that enrollees and applicants are provided timely written notice of any determinations required to be subject to review under § 457.1130 that includes the reasons for the determination; an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, and the manner in which a review can be requested; and the circumstances under which enrollment may continue pending review. Section § 457.340(d) requires that in the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

We provide States with flexibility under § 457.1190 related to coverage provided through premium assistance programs to assure that all SCHIP eligible children have access to these enrollee protections, while recognizing States' reduced ability, or in some cases inability, to affect group health plan review procedures. This section provides that in States choosing to offer premium assistance programs, if the group health plan(s) through which coverage is provided are not found to meet the review requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180, the State must give applicants and enrollees the option to obtain health benefits coverage other than coverage through that group health plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

1. Overview of Enrollee Rights (Proposed § 457.995)

In the proposed rule, we set forth in § 457.995 an overview of certain enrollee rights that we provided throughout the proposed rule. In determining the scope of consumer protections to apply to separate child health programs, we considered the Secretary's statutory authority under title XXI and, within that authority, we attempted to balance the goal of ensuring consumer rights for SCHIP-eligible children with the need to afford States flexibility to design their separate child health programs. In this spirit, we proposed the enrollee protections listed in proposed § 457.995 for enrollees in separate child health programs, and we also solicited public comments on how best to balance these interests in this regulation.

As noted above, while we removed proposed § 457.995 from the regulation text in response to public comment, we respond to the general comments on proposed § 457.995 below. We respond to comments on the specific provisions cross-referenced in the § 457.995 overview and contained in other subparts along with the responses to other comments on those cross-referenced provisions. For example, proposed § 457.995 contains a cross-reference to § 457.110 and the comments to proposed § 457.995 also included comments on § 457.110. We respond to the latter set of comments on § 457.110 together with the other comments on § 457.110. Below you will find our responses to the general comments on § 457.995. Following our responses to general comments on this section is an overview of the enrollee protections provided in this final regulation.

Comment: One commenter suggested that HCFA either (1) consolidate all of the sections that relate to enrollee protections in one or two sections; or (2) leave the protections in different parts of the proposed rule, ensure that the protections are consistent with the CBRR, and provide a summary of the protections in the preamble only. While this commenter strongly supported HCFA's attempt to address the CBRR, the commenter believed that the proposed rule does not incorporate the rights and requirements in a logical fashion. They noted that § 459.995 merely summarized requirements found in other sections of the rule, so it seemed redundant and, at times, inconsistent. According to this commenter, for example, § 457.110(b) provided that information provided to enrollees must be ''accurate'' and ''easily understood'' and that the information must be ''made available to applicants and enrollees in a timely manner.'' Proposed § 457.995(a)(4), however, provided that ''information must be accurate and easily understood and provide assistance to families in making informed health care decisions.'' These two provisions addressed similar issues but included slightly different requirements, and this commenter argued that these inconsistencies are difficult to reconcile and therefore could result in inappropriate interpretations by States, courts, and enrollees. This commenter generally requested that HCFA reconcile the substantive requirements in other sections of the regulations with the requirements in § 457.995(a) and (b).

The commenter also recommended that the provision relating to ''assistance'' include a reference to ''application assistance'' in § 457.361(a) and to translation services. The same commenter suggested that HCFA correct the citations referenced in § 457.995(a)(3). A different commenter noted that there is no § 457.735(c), and the reference in § 457.995(b) to § 457.735(c) should instead be to § 457.735(b). One commenter also suggested that HCFA divide § 457.995(c) regarding access to emergency services into two separate sections: ''access'' and ''cost sharing for emergency services.''

Response: We agree with the comments about the inconsistency between § 457.995 and certain other substantive sections of the regulation. As noted above, to avoid confusion, we removed proposed § 457.995 from the regulation text and provide an overview in the preamble of the enrollee protections provided throughout the regulation. As for the comments about the cross-references and the need to address certain issues separately, we made every effort to ensure that the cross-references in the final regulation are correct and that issues are adequately addressed in the regulation provisions and explained in the overview now provided in the preamble.

Comment: Many commenters expressed support for HCFA's decision to incorporate the CBRR provisions in the proposed regulations. One

commenter specifically noted that the rights to apply for assistance, to have applications processed in a timely manner, to be informed about benefits, participating providers and coverage decisions, and to have access to a fair process to resolve disputes are basic consumer protections that are critical to ensuring that the program's promise of health care coverage becomes a reality. Another commenter supported the recognition of consumer protections relating to emergency services, participation in treatment decisions, and respect and nondiscrimination. One commenter expressed support for HCFA offering States a good deal of flexibility in the application of these requirements.

Response: We appreciate the support expressed by the commenters.

Comment: Several commenters believed that HCFA exceeded its statutory authority in applying the CBRR to title XXI regulations. Several commenters recommended deleting section § 457.995 because, in their view, there is no basis for implementation of the CBRR in title XXI and, in many cases, States already have Patient Bill of Rights laws. One commenter noted that children in Medicaid expansion programs will be covered under consumer protections available in Medicaid, while children in separate child health programs will be covered under State consumer protection laws. One commenter suggested that, where a conflict exists, or similar requirements are imposed by State law, State law should prevail. This same commenter urged HCFA to consider a ''substantial compliance'' process in these instances. Several other commenters added that they support protecting health care consumers, but that, in their view, requiring the States to implement specific consumer protections for SCHIP could have additional fiscal and administrative impact on their programs.

Response: In establishing the applicant and enrollee protections, we did not simply import the CBRR. We considered our statutory authority, the nature and scope of State laws that might apply to separate child health programs, the need for minimum consumer protection standards, and the States' authority under title XXI to design their own program consistent with the requirements of Federal law. There is statutory authority under title XXI for each enrollee protection included within this final regulation as outlined in the overview and set forth in this part. We describe the statutory authority for each of the enrollee protections in the preamble to each proposed section containing an enrollee protection, in the ''Basis, Scope, and Applicability'' regulation section of each subpart containing one of the enrollee protections, and often in our responses to the specific comments on the sections or subparts of the proposed rule containing the enrollee protections. While we removed § 457.995 from the regulation text, this was done for clarity and to promote consistency, and does not reflect any change in our position regarding the statutory authority for the cited enrollee protections.

States are required to ensure that enrollees in separate child health programs are afforded the minimum consumer protections set forth in this regulation. These minimum protections set a framework within which States may design their procedures consistent with applicable State laws, and we believe it will not be difficult to ascertain whether Federal or State law prevails. If a contractor serving enrollees in a separate child health program is subject to State consumer protection law that is more prescriptive in the areas addressed in this regulation, then in complying with State law, the contractor will comply with this Federal regulation as well. For example, if a State law requires the completion of its review processes for certain health services decisions within a shorter time frame than does this regulation, the State will comply with both Federal and State law when it complies with the shorter State-required time frame. On the other hand, if the Federal time frame requirement is shorter, the Federal requirement will prevail. We have set specific time frames in only a limited number of circumstances to establish the outer boundaries of an efficient and effective system that accomplishes the purpose of the Act. Given the scope of the flexibility afforded States under these rules, we expect that the instances where these Federal rules will impose more stringent standards than those imposed by State law, in those States with an applicable State law, will be limited. In addition, the processes by which certain disputes are resolved are left completely to States' discretion; in such cases, State rules will control. By requiring that a State delineate review procedures in its State plan, we expect the State plan development process, including public notice and comment, will promote State-specific approaches to designing review procedures that reflect local issues and accommodate the State's administrative structure, while ensuring minimum protections to applicants and enrollees.

We will work with States to resolve any questions that might arise in a particular State. No additional compliance process will be instituted beyond that which is already established in subpart B of part 457 under the authority of section 2106(d)(2) of the Act, which requires States to comply with the requirements under title XXI and empowers HCFA to withhold funds in the case of substantial noncompliance with such requirements.

As for the fiscal impact of these requirements, we do not believe that the costs need to be large relative to the cost of services provided to enrollees. The protection of enrollee rights is a critical component of program costs for the provision of child health assistance. States retain broad flexibility to design and implement efficient and effective review processes. Because these regulations do not prescribe any particular review process, States have the flexibility to rely on other already established State review processes for the purpose of resolving disputes that arise in the context of their separate child health programs.

Comment: One commenter noted that, in the preamble to the proposed regulation, we cited a Presidential directive on the CBRR as justification for imposing requirements on State child health plans. This commenter believes that this justification was not sufficient because the proposal conflicted with Executive Order 13132 provisions limiting federal agencies from unnecessarily limiting State flexibility. This commenter expressed the view that HCFA lacks authority to impose the CBRR upon the States to the extent that the CBRR contradicts Congress' unambiguous intent when enacting title XXI and to the extent that it conflicts with E.O. 13132. In this commenter's view, title XXI was designed to provide flexibility to the States in creating and implementing SCHIP programs, and requires the States to describe to HCFA the different aspects of the State plans with minimal restrictions. This commenter argued that, although Congress adopted a general approach intended to allow States to design and experiment with their programs, HCFA has applied the CBRR to remove States' flexibility, and has brought the CBRR to bear most heavily on States that exercised that flexibility. This commenter asserted that a State should be able to tailor its own program to achieve the broad goals of the CBRR and should be able to do so by innovative means tailored to the needs of its population. In this commenter's opinion, we could ''cure'' the regulation (1) by eliminating proposed §§ 457.985, 457.990 and 457.995; and, more importantly, (2) by

evaluating each separate program on its own terms.

Response: As noted above, there is statutory authority for each applicant and enrollee protection outlined in the overview and set forth in this part. In considering how to develop applicant and enrollee protections for this regulation generally, we attempted to balance the important goal of ensuring consumer rights for the SCHIP-eligible population with the flexibility afforded States under title XXI to design their separate child health programs, and we have also considered the value of enrollee feedback through the review process in ensuring compliance with program requirements. In all instances, we have based our regulations on the provisions of title XXI. In our view, the final regulations comply with title XXI and are consistent with the CBRR and E.O. 13132. The regulations establish minimum standards and offer States the opportunity to design their own systems and procedures consistent with these standards. This final regulation does not require a uniform system for providing basic protections to children and their families but rather recognizes and permits significant State-by-State variation.

Comment: One State expressed concern that the level of detail of the CBRR provisions in the proposed regulation severely limits States' flexibility in contracting and hampers their ability to adjust contract provisions that are not working well. Another commenter stated that HMOs and insurers would be less likely to participate in SCHIP if they have to implement both the State requirements and the requirements within the proposed rule, which may have conflicting language.

Response: We appreciate the commenters' concerns and have taken the comments into account in these final regulations. In order to provide all applicants and enrollees the protections established by these regulations pursuant to title XXI, it is essential for contracts to reflect the provisions in this final regulation. However, while we included several important protections within this regulation, we also omitted other details and protections provided by the CBRR, to allow States to design their own review procedures and to minimize any conflict with applicable State law. States have flexibility in the design and implementation of applicant and enrollee protections and we are available to provide technical assistance to States and to facilitate discussions among States as they develop or revise contracts so that they comply with the final regulations. We will also share information about successful State practices among the other States.

Comment: One commenter recommended that HCFA use national standards in applying the principles outlined in the CBRR, such as the Standards on Utilization Management and Member Rights and Responsibilities of the National Committee for Quality Assurance (NCQA). This commenter believed that a standardized system reduces administrative complexity and cost and is more likely to benefit all managed care enrollees. The commenter recommended that the final rule include provisions that allow States to adopt other systems that comport with the BBA and HCFA's Quality Improvement Standards for Managed Care objectives (QISMC), subject to review and approval by HCFA.

Response: We appreciate the recommendation for using the standards issued by NCQA, a private organization that accredits managed care entities, on Utilization Management and Members Rights and Responsibilities. We encourage States to explore such models as a means to develop and implement high quality processes that protect applicant and enrollee rights in a comprehensive manner. While there are advantages to a standardized system, we considered such models and opted to develop minimum standards and permit States the ability to adopt or vary from such models, as long as the standards established by the final regulations are met.

Comment: Several commenters suggested that a provision be added to § 457.995 to require States to include in their managed care contracts provisions that implement all relevant State laws in the area of managed care consumer protections. One of these commenters believed that State law protections should apply to State contracts with entities arranging for the delivery of care that might not be licensed insurance carriers.

Response: While we recognize the importance of the managed care consumer protections contained in many States' laws, we do not require that the contracts comply with State consumer protection laws applicable to certain health plans. The inclusion of such protections in SCHIP contracts is a matter of State law. To the extent that a managed care entity or entity that contracts with a State in connection with its SCHIP program is subject to State insurance or business laws, the entity would be required to comply with applicable State law. We encourage States to include in their contracts with health plans, or other organizations, the applicable patient protections required under State law to the extent they do not conflict with the standards in this regulation.

Comment: One commenter suggested that this overview section also list enrollees' rights to linguistic access to services. This commenter recommended that the preamble explain these rights and provide examples, such as providing bilingual workers and linguistically appropriate materials that include recommendations on how States and contracted entities can comply. Another commenter requested that cultural competency and linguistic accessibility requirements be incorporated throughout the provisions on information, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and nondiscrimination, and grievances and appeals.

Response: We addressed these comments in subpart A along with other comments on §§ 457.110 and 457.130 involving compliance with civil rights requirements and the linguistic appropriateness of information provided to enrollees.

Overview of Applicant and Enrollee Protections in Final Regulation

In this final rule, we require States to provide certain protections for applicants and enrollees in separate child health programs. Outlined below are the protections afforded under this regulation.

- Information Disclosure

Section 457.110 provides that States must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants, and enrollees and provide assistance to families in making informed health care decisions about their health plans, professionals, and facilities. In addition, this section that families be provided information on physician incentive plans as required by the final regulation at § 457.985. We also require, at § 457.65(b), that a State must submit a State plan amendment if it intends to eliminate or restrict eligibility or benefits, and that the State certify that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law, and that public notice occurred before the requested effective date of the change.

Under § 457.350(g), we require States to enable families whose children may be eligible for Medicaid to make informed decisions about applying for Medicaid or completing the Medicaid application process by providing information in writing on the Medicaid program, including the benefits covered

and restrictions on cost sharing. Such information must also advise families of the effect on eligibility for a separate child health program of neither applying for Medicaid nor completing the Medicaid application process. Finally, § 457.525 provides that the State must make a public schedule available that contains the following information: current cost-sharing charges; enrollee groups subject to the charges; cumulative cost-sharing maximums; mechanisms for making payments for required charges; and the consequences for an applicant or enrollee who does not pay a charge, including the disenrollment protections required in § 457.570.

• Choice of Providers and Plans

The rules provide enrollees with certain protections regarding choice of providers and plans through §§ 457.110 and 457.495. Section 457.110 provides that the State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants, and enrollees, and provide assistance to families in making informed health care decisions about their health plans, professionals, and facilities. Section 457.495 provides that, in its State plan, a State must describe its methods for assuring: (1) The quality and appropriateness of care provided under the plan particularly with respect to well-baby, well-child and adolescent care, and immunizations; (2) access to covered services, including emergency services as defined at § 457.10; (3) and appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to specialists experienced in treating the specific medical condition; and (4) that decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days of the receipt of a request for services.

• Access to Emergency Services

Sections §§ 457.410(b), 457.515(f), 457.555(d), and 457.495 address the right to access emergency services. Section § 457.10 defines ''emergency medical condition'' and ''emergency services'' using the ''prudent layperson'' standard recommended by the President's Advisory Commission and adopted by many States in their consumer protection laws. Section 457.410(b) requires that regardless of the type of health benefits coverage offered under a State's plan, the State must provide coverage for emergency services as defined in § 457.10.

Under § 457.555(d), for targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of $10.00, for services furnished in a hospital emergency room if those services are not emergency medical services as defined in § 457.10. Under § 457.515(f), States must assure that enrollees will not be held liable for cost-sharing amounts beyond the co-payment amounts specified in the State plan for emergency services provided at a facility that does not participate in the enrollee's managed care network. Section 457.495(b) provides that in its State plan, a State must describe its methods for assuring the quality and appropriateness of care provided under the plan particularly with respect to access to covered services, including emergency services as defined at § 457.10.

• Participation in Treatment Decisions

This regulation gives enrollees in separate child health programs the right and responsibility to participate fully in treatment decisions. Under § 457.110, the State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants and enrollees and provide assistance to families in making informed health care decisions about their health plans, professionals, and facilities. The State must also make available to applicants and enrollees information on the amount, duration and scope of benefits and names and locations of current participating providers, among other items. In addition, under § 457.985, States must guarantee that its contracts for coverage and services comply with the prohibition on interference with health care professionals' advice to enrollees, requirement that professionals provide information about treatment in an appropriate manner, the limitations on physician incentive plans, and the information disclosure requirements related to those physicians incentive plans referenced in that provision. We also require under § 457.110(b)(5) that the State have a mechanism in place to ensure that information on physician incentive plans, as required by § 457.985, is available to potential applicants, applicants and enrollees in a timely manner. We also provide under § 457.130 that the State plan must include an assurance that the State will comply with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

• Civil Rights Assurances

In § 457.130, we require in the State plan an assurance that the State will comply with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR parts 80, 84, and 91, as well as 28 CFR part 35. These civil rights laws prohibit discrimination based on race, sex, ethnicity, national origin, religion, or disability.

• Confidentiality of Health Information

The regulations address this right in § 457.1110, which provides privacy protections to enrollees in separate child health programs. Under that section, the State must ensure that, for medical records and any other health and enrollment information maintained with respect to enrollees (in any form) that identifies particular enrollees; the State and its contractors must establish and implement certain procedures to ensure the protection and maintenance of this information.

• Review Process

Sections 457.1130(b) and 457.1150(b) provide that enrollees in separate child health programs must have an opportunity for an independent external review by the State or a contractor, other than the contractor responsible for the matter subject to external review, of a decision by the State or its contractor to delay, deny, reduce, suspend, or terminate health services, in whole or in part, including a determination about the type or level of services; or for failure to approve, furnish, or provide payment for health services in a timely manner. Section 457.1160(b) sets a time frame under which this process must occur, including an expedited time frame in the case where an enrollee's life or health or ability to attain, maintain or regain maximum function are in jeopardy.

2. Basis, Scope, and Applicability § 457.1100

This subpart interprets and implements section 2101(a) of the Act, which provides that the purpose of title XXI of the Act is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; section 2102(a)(7)(B) of the Act, which requires that the State plan

include a description of the methods used to assure access to covered services, including emergency services; section 2102(b)(2) of the Act, which requires that the State plan include a description of methods of establishing and continuing eligibility and enrollment; and section 2103, which outlines coverage requirements for a State that provides child health assistance through a separate child health program. This subpart sets forth minimum standards for applicant and enrollee protections that apply to separate child health programs.

3. Definitions and Use of Terms (Selected Provisions of Proposed § 457.902)

Below we will address the comments on the definitions in proposed § 457.902 and terms used in proposed § 457.985 that relate to the applicant and enrollee protections set forth in this new subpart K.

In proposed § 457.902, we defined contractor as ''any individual or entity that enters into a contract, or a subcontract to provide, arrange, or pay for services under title XXI of the Act. This definition includes, but is not limited to, managed care organizations, prepaid health plans, primary care case managers, and fee-for-service providers and insurers.'' As stated in the preamble to the proposed rule, we defined the term contractor in proposed § 457.902 because it is used most significantly in reference to accountability for ensuring program integrity. However, we also used the term in proposed § 457.985 relating to grievances and appeals. Because the term is now used in subparts I and K, we moved the definition of contractor to § 457.10. We retained the definition of contractor set forth in the proposed regulation. We defined the term ''grievance'' in proposed § 457.902 as ''a written communication, submitted by or on behalf of an enrollee in a child health program, expressing dissatisfaction with any aspect of a State, a managed care or fee-for-service entity, or a provider's operations, activities or behavior that pertains to—(1) The availability, delivery, or quality of health care services, including utilization review decisions that are adverse to the enrollee; (2) payment, treatment, or reimbursement of claims for health care services; or (3) issues unresolved through the complaint process established in accordance with § 457.985(e).'' In the preamble to the proposed rule, we indicated that we ''defined the term 'grievance' to provide some context into the section requiring States to have written procedures for grievances and appeals.'' We defined the term grievance to be consistent with the proposed Medicaid managed care regulations, and to give the States the opportunity to utilize the process that is already in place for the Medicaid program.

As noted earlier, we are now referring to the procedural protections afforded to applicants and enrollees in separate child health programs under this regulation as a ''review process.'' Because the term grievance is no longer used or needed in our provisions regarding the review process, we removed the definition from the regulation text.

Comment: One commenter noted that there is a definition of the term ''grievance,'' but no definition of the term ''appeal.'' Another commenter proposed that we delete the definition of grievance. Several commenters recommended that HCFA ensure that the terms ''grievance'' and ''appeal'' are employed consistently across all programs, including Medicare, Medicaid and SCHIP; these commenters expressed confusion about different uses of the terms ''grievance,'' ''appeal'' and ''complaint'' in these other programs. One commenter also questioned whether the reference to § 457.985(e) was intended to be to § 457.985(d). This commenter recommended that it would be clearer for HCFA to use the terminology used in the proposed Medicaid managed care regulations. Another commenter argued that federal requirements for resolving enrollee complaints and grievances will reduce plan participation because many plans will not be willing to have separate processes for SCHIP enrollees that exceed existing State statutory requirements.

Response: Consistent with our modified approach to requirements in this area, under which we give States flexibility in how they choose to handle many types of disputes, we removed the definition of ''grievance'' from the regulation text. We are now referring to the procedural protections afforded to enrollees in separate child health programs under this regulation as a ''review process.'' Therefore, we did not add a definition of ''appeal.'' We rectified the incorrect cross-reference noted by the commenter in removing the definition of grievance from the regulation text. We agree that, to the extent that we intend to impose Medicaid requirements, we should use the same terminology. In this regulation, however, we determined not to require States to adopt the Medicaid approach to review processes, but we did attempt to use consistent terminology as appropriate.

In order to assure the fair and efficient operation of SCHIP and to ensure that children eligible for coverage under separate child health programs have access to the health care services provided under title XXI, these final rules establish minimum consumer protection standards for applicants and enrollees in separate child health programs balancing a recognition that State law varies in this area with the need to assure certain protections to all children, regardless of where they live. If a contractor serving separate child health program enrollees is subject to State consumer protection law that is more prescriptive in the areas addressed by this regulation, then the contractor, in complying with State law, will comply with this Federal regulation as well.

Comment: Several commenters believed the term ''contractor'' as used in § 457.985(a) is too broad. One commenter said the definition appeared to include every fee-for-service physician that serves a participant in a separate child health program. According to this commenter, this rule makes such a physician's decision to provide Tylenol instead of an antibiotic subject to a grievance procedure. The commenter noted that this policy may discourage physician participation in the program and recommended that the statement exclude those providers to whom the enrollee is not ''locked in'' or whom the enrollee is not otherwise required to utilize. One commenter noted that inconsistency in the use of ''participating contractors'' in § 457.995(g)(1) and ''participating providers'' in § 457.985(a) resulted in confusion. Another commenter believed that the term ''participating providers'' as used in § 457.985(a) needed to be clarified because ''providers'' are generally defined as health care professionals, agencies or institutions. It was also not clear to this commenter why ''health providers'' would be included in this directive. If the term intended was contractors, in the view of this commenter, § 457.985(a) should be amended. If another meaning is intended, the commenter recommended that it be added to the definitions at § 457.902.

Response: We intended to include in the term ''contractor'' any individual or entity that would enter into a contract with a State to furnish child health assistance to targeted low-income children. As reflected in §§ 457.1130(b) and 457.1150(b), we believe enrollees must have an opportunity for an independent, external review of a

determination to delay, deny, reduce, suspend, or terminate health services, in whole or in part, including a determination about the type or level or services; or for failure to approve, furnish, or provide payment for health services in a timely manner. This right applies whether or not the actions mentioned were taken by a State directly or by a contractor. Because we believe that we accomplish this goal with the definition as proposed, we did not modify the definition of contractor. We agree that we created confusion by using ''participating contractors'' and removed § 457.995(g)(1) and its reference to ''participating contractors'' from the regulation text. We also agree that we created confusion by using the term ''participating providers'' and not defining it. Our intent was to ensure that applicants and enrollees receive written notice of decisions that they have the opportunity to challenge through a review process. In § 457.1180, we did not use the term ''participating providers,'' and clarified that a State must assure that applicants and enrollees receive timely written notice of any determinations subject to review under § 457.1130. This could be accomplished, for example, by requiring contracting managed care entities to provide notice either directly or through a provider serving as an agent of that entity.

4. Privacy Protections § 457.1110 (Proposed § 457.990)

We proposed that the State plan must assure that the program complies with the title XIX provisions as set forth under part 431, subpart F—Safeguarding Information on Applicants and Recipients. Moreover, we proposed that the State plan must assure the protection of information and data pertaining to enrollees by providing that all contracts will include guarantees that:

- Original medical records are released only in accordance with Federal or State law, or court orders or subpoenas;
- Information from or copies of medical records are released only to authorized individuals;
- Medical records and other information are accessed only by authorized individuals;
- Confidentiality and privacy of minors is protected in accordance with applicable Federal and State law;
- Enrollees have timely access to their records and to information that pertains to them; and
- Enrollee information is safeguarded in accordance with all Federal and State laws relating to confidentiality and disclosure of mental health records, medical records, and other information about the enrollees.

We proposed that State child health plans are subject to any Federal information disclosure safeguard requirements as well as requirements set forth by their State regarding information disclosure, including use of the Internet to transmit SCHIP data between and among the State and its providers. We also proposed that electronic transmission of data to HCFA must comply with HCFA's policies and requirements regarding privacy and confidentiality of data transmissions. Data transmissions between providers, health plans, and the State would be subject to these requirements. Finally, we proposed to provide that the State must assure that the program will be operated in compliance with all applicable State and Federal requirements to protect the confidentiality of information transmitted by electronic means, including the Internet.

Comment: One commenter strongly supported the inclusion of the Medicaid privacy protections for all SCHIP enrollees and the listed contract requirements regarding information protection and access for enrollees.

Response: We appreciate the commenter's support for the inclusion of the specific language relating to the Medicaid provisions, and we have retained this requirement in the final rule. As for the listed contract requirements regarding information protection and access for enrollees, we have modified slightly our requirements in the final rule. Specifically, we are requiring that for medical records and any other health information maintained with respect to enrollees that identifies particular enrollees, States and their contractors must abide by all applicable Federal and State law regarding confidentiality and disclosure; maintain records and information in a timely and accurate manner; specify the purpose for which information is used and disclosed; and except as provided by Federal or State law, ensure that enrollees may request and receive a copy of their records and request that information be supplemented or corrected. To minimize potential inconsistencies with other Federal regulations, we have removed the specific references to safeguarding electronic data transmissions, including the use of the Internet to transmit SCHIP data. Similarly, we have eliminated the language requiring safeguarding of information because subpart F of part 431 already includes such a requirement. We also clarify that original medical records and other identifiable information must be offered the same level of protection under this rule. These revisions should not be interpreted as a reduction in privacy protections. The protections addressed by the commenter will be afforded to SCHIP applicants and enrollees in separate child health programs, consistent with any other applicable law.

Comment: Two commenters supported the provision requiring that the State plan must provide that all contracts will include guarantees that protect the confidentiality and privacy of minors, subject to applicable Federal and State law. One commenter noted that both State and Federal law contain a variety of provisions that protect the confidentiality of minors. According to this commenter, minor consent statutes in every State accord minors the right to give their own consent for services and often provide confidentiality protection for minors as well. Another commenter believed that confidentiality is critical to ensure that adolescents seek health care services, particularly those related to reproductive health. Both adolescents and providers consistently identify concerns about confidentiality as a major obstacle to health care for adolescents. This commenter urged HCFA to encourage States to ensure that all information, including statements explaining benefits related to reproductive health services and family planning, is provided to enrollees in a confidential manner.

Response: We appreciate these commenters' support. The final rule requires States to abide by all applicable Federal and State laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information.

Comment: One commenter recommended that HCFA explain in the preamble language how these privacy protections interact with the privacy standards proposed in October 1999 and the security standards proposed in August 1998. This commenter believed that it is extremely important that all of the protections are harmonized so that the legal interpretations of State and contractor obligations are not unnecessarily confusing. Other commenters noted that the SCHIP protections should be consistent with the rulemaking on Standards for Privacy of Individually Identifiable Health Information (**Federal Register**, November 3, 1999).

One commenter expressed general concern about what they viewed as the lack of consistency across the federal government and the States regarding privacy standards. The commenter noted that dual regulation increases compliance costs, which are ultimately passed on to enrollees and consumers. This commenter specifically suggested that § 457.990(b) be deleted and replaced with a requirement that the State health plan must assure the protection of information and data pertaining to enrollees by providing that all contracts contain identical privacy protections as required under current federal Medicaid contract requirements. If this change was not acceptable, the commenter had alternative suggestions. The commenter first noted that the term ''authorized individuals'' is not defined in § 457.990(b)(2) and § 457.990(b)(3) and suggested that clarification is necessary to ensure that this definition includes all parties needing access to enrollee information for treatment, administration, payment, health care operations and other appropriate purposes consistent with Medicaid standards. Second, this commenter suggested the need to clarify in § 457.990(b)(5) that enrollees' right to access information pertaining to them falls under the Federal Privacy Act of 1974.

Response: We agree with the need to harmonize the SCHIP privacy requirements and other Federal privacy law and policy, and as a result have made several changes to this section. In revising § 457.1110, we examined the proposed Medicaid Managed Care regulation (63 FR 52022), the proposed Medicare+Choice regulation (63 FR 34968), and the proposed requirements set forth under the authority of the Health Insurance Portability and Accountability Act (HIPAA). Additionally, we acknowledge the commenters' point that ''authorized individuals'' was not defined and have deleted it from the final regulations so as not to conflict with Federal or State law addressing permissible disclosures. We also elected not to specify particular Federal or State laws in the final regulation (in order to clarify that we intend to require that States follow all applicable Federal and State laws, including laws and regulations not yet finalized or developed).

Comment: One commenter recommended that HCFA review the American Academy of Pediatrics policy statement, ''Privacy Protection of Health Information: Patient Rights and Pediatrician Responsibilities'' (Pediatrics Vol. 104 No. 4, October 1999).

Response: We appreciate the suggestion that we review the Academy's report, and in our review found that it provided useful information regarding patient rights and pediatrician responsibilities from the Academy's perspective. We encourage providers and others to review the report for additional information on complying with aspects of Federal and State privacy law. For the purposes of this regulation, however, we attempted to harmonize the privacy requirements for separate child health programs with other applicable Federal law, and opted not to adopt additional measures.

Comment: One commenter expressed that § 457.995(f) is awkward in that it excludes confidentiality protections and access rights afforded by other laws, such as local or tribal laws, as well as industry practices that are more protective of confidentiality and provide greater access to health information. This commenter recommended removing the words ''only'' and ''federal and State law'' from § 457.995(f) so that it reads: ''States must ensure the confidentiality of a enrollee's health information and provide enrollees access to medical records in accordance with applicable law (§ 457.990).''

Response: As noted above, we removed § 457.995(f) from the regulation text. We considered this comment, however, with respect to proposed § 457.990(b)(1), (b)(4), and (b)(6). We did not intend the proposed privacy protections to preclude greater local or tribal protections or protections of enrollee access to information. However, depending upon the applicable Federal or State law, it is possible that local or tribal protections could be preempted if the Federal or State law in questions requires a preemption.

Comment: One State indicated that its separate child health program uses a premium assistance program under which it would not contract for health services and therefore would not have a mechanism to enforce the proposed privacy requirements. The State indicated that the mechanism available to impose these requirements is the State Insurance Code, and recommended it be recognized.

Response: States are required to ensure that enrollees in separate child health programs are covered by the minimum privacy protections defined under § 457.1110 of this regulation, regardless of what model is used to deliver services under a separate child health program funded with Federal SCHIP funds. If the premium assistance program is subject to State insurance law that requires the minimum privacy protections consistent with those set forth by this regulation, then the State will be in compliance with this requirement. If a group health plan participating in the State's premium assistance program does not comply with the minimum privacy requirements set forth in this regulation, then the State may not provide SCHIP coverage to separate child health program enrollees through that group health plan.

5. Review Processes §§ 457.1120–457.1190 (Proposed § 457.985)

In the proposed rule, we provided that the State and its participating providers must provide applicants and enrollees written notice of the right to file grievances and appeals in cases where the State or its contractors take action to: (1) deny, suspend or terminate eligibility; (2) reduce or deny services provided under the State's benefit package; (3) disenroll for failure to pay cost sharing. In addition, proposed sections §§ 457.365, 457.495, and 457.565, respectively, required that § 457.985 apply in these specific circumstances. In § 457.361(c), we proposed to require that the State must send each applicant a written notice of the decision on the application and if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable amount of time.

We further proposed in § 457.985(d) that the State must establish and maintain written procedures for addressing grievances and appeal requests, including processes for internal review by the contractor and external review by an independent entity or the State agency. We proposed that these procedures for grievances must comply with the State requirements for grievances and appeals that are currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) within the State. We proposed that procedures must include a guarantee that the grievance and appeals requests will be resolved within a reasonable period of time.

We also proposed that States may elect to use the grievance procedures as described in part 431, subpart E regarding fair hearings for Medicaid applicants and recipients, and the Medicaid grievance and appeal procedures for Medicaid managed care entities, which were set forth in the Medicaid Managed Care proposed rule (63 FR 52022).

We further proposed to require that the States and their contractors must

have in place a meaningful process for reviewing and resolving complaints that are submitted outside of the grievance and appeals procedures as part of the quality assurance process.

In addition, we proposed at § 457.985(e) that the State must guarantee, in all contracts for coverage and services, enrollee access to information related to actions which could be subject to appeal in accordance with the ''Medicare+Choice'' regulation at § 422.206, which prohibits ''gag rules'' and protects enrollee-provider communications, and § 422.208 and § 422.210, which address limitations on physician incentive plans and requirements for information disclosure to enrollees related to those plans.

Following are responses to comments on proposed § 457.985.

Comment: One commenter suggested reorganizing § 457.985 into a more logical format to keep all of the grievance sections in one subpart, with cross-references as appropriate.

Response: We agree with this comment and made appropriate changes to the regulation text to consolidate provisions relating to the review process. In this final regulation, we moved proposed § 457.985(a),(b),(c), and (d) relating to review procedures from subpart I to subpart K, and further revised and clarified these sections.

We retained subparagraph (e) related to provider-enrollee communications and limits on physician incentives as the whole § 457.985 in subpart I. In addition, to improve clarity and to be responsive to comments, we revised that section.

Sections §§ 457.1120–457.1190 are the provisions of the final regulation that represent the reworking of proposed § 457.985. Subpart K now contains most of the provisions relating to the review process, and related provisions in other subparts were revised or deleted as appropriate, to be consistent with the provisions of subpart K.

Comment: Many commenters noted that the lack of minimum standards may cause lengthy time periods for completion of grievance and appeals processes, leaving many enrollees without needed benefits. The commenters believed that, despite the difficulties in establishing a grievance and appeals system that addresses the needs of States, participating contractors, Medicaid, and SCHIP, consistency between the Medicaid and SCHIP procedures is integral to ensuring ease of administration for providers and quality care for enrollees. The commenters noted that because enrollees may transfer between Medicaid and SCHIP at different times, consistency in the application of grievances and appeals processes would eliminate confusion. The commenters recommended that HCFA establish a set of minimum standards the States and participating providers must meet when providing services to enrollees.

Response: In finalizing this regulation, we attempted to strike a balance between State flexibility and enrollee protection consistent with the provisions and framework of title XXI. Rather than requiring Medicaid grievance and appeal requirements for separate child health programs, we adopted core elements for a review process under § 457.1140, and minimum standards for impartial review, under § 457.1150, that States with separate child health programs must meet. We also included, under § 457.1160, specific time frames for review of health services matters and a requirement that review of eligibility and enrollment matters be completed within a reasonable amount of time. We also required, in both cases, that States consider the need for expedited review in appropriate circumstances. We recognize that enrollees will often move between the two programs, and we encourage States to standardize the review processes to the extent possible and rely on Medicaid procedures when it is advisable to do so. In § 457.110, we also require that States notify potential applicants, applicants and enrollees of the procedural protections afforded to applicants and enrollees under the separate child health program. This information should help ease transition between Medicaid and separate child health programs, to the extent that a State chooses to implement different review systems.

Comment: Several commenters believed that grievance and appeal rights are inappropriate for title XXI. Likewise, one commenter believed that SCHIP is not an entitlement program and should not be subject to the grievance procedures required for entitlement programs. In the view of this commenter, HCFA has exceeded its statutory authority in applying the CBRR to the title XXI regulations. One commenter recommended deleting § 457.985 because, in their view, there is no basis for the development of Federal grievance or appeal processes in title XXI, and expressed that States should have the flexibility to develop and apply processes consistent with State law. Another commenter recommended also deleting § 457.365 because they believed we had exceeded our authority, and recommended that in the final rule a reference to all eligibility actions (denial, suspension, and termination) be incorporated in § 457.361(c).

Response: We acknowledge that a separate child health program may be quite different from a State's Medicaid program, and the final regulation does not require States to comply with the Medicaid requirements for grievance and appeal procedures. However, we believe that States operating separate child health programs under title XXI need to establish a review process and comply with minimum standards. While title XXI provides States with a great deal of flexibility, section 2101(a) of the Act provides that the ''purpose of the title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.'' As we asserted in the preamble to the proposed rule, review processes that meet certain minimum standards are essential components of State programs in order to assure that child health assistance is provided in an effective and efficient manner.

Moreover, section 2102(b)(2) requires that a State plan include a description of methods ''of establishing and continuing eligibility and enrollment.'' Procedures to address adverse determinations related to eligibility or enrollment are necessary for ensuring accurate assessments of initial and ongoing eligibility. Section 2102(a)(7)(B) requires a State in its State plan to describe methods used ''to assure access to covered services.'' This section supports our requiring minimal standards for a review process designed to ensure that eligible children have access to covered services, including an expedited review process when there is an immediate need for health services. Section 2103 also requires a specific scope of coverage, and provides the authority for the provisions of the final regulation that seek to assure that a meaningful review process is in place to enforce that access requirement. In the final regulation, eligibility actions and procedural protections related to such actions are described in §§ 457.1130(a), 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180.

Comment: Several commenters believed States should be allowed to use existing appeal mechanisms for managed care. One commenter noted opposition to Federal requirements that would force the States to alter standard commercial plan contracts (for example, specific appeals criteria or procedures), and urged HCFA to allow States to develop appeals and grievance procedures that are consistent with State insurance regulations. Another

commenter noted that under New York law, Child Health Plus enrollees are granted broad grievance and utilization review rights, as well as external appeal rights for certain determinations. These rights are set forth in detail in the member handbook or contract, and whenever services under the program are denied as not medically necessary, individuals are advised of their appeal rights. This commenter supported allowing States to use existing procedures in lieu of ''Medicaid-style'' procedures. One commenter noted that such an approach is more efficient and that a separate grievance process would be problematic because the costs of it would be subject to the 10 percent administrative cap.

Response: As noted above, we do not require any particular type of review process. States have discretion under these rules to design their own review process and we fully expect that such procedures may vary from State to State while still operating consistent with the requirements adopted here. We recognize, however, that our review process requirements might necessitate changes in standard commercial contracts if such contracts are used in separate child health programs. However, we believe that these changes are likely to be minimal given the broad discretion left to States to establish their review procedures. The regulations provide a minimum level of protection to applicants and enrollees in separate child health programs. To the extent that the State health insurance law on reviews is more stringent than, but also complies with, these requirements and the State or its contractor is subject to that State health insurance law, these rules will not impose any new requirements on States or their contractors. We believe that title XXI ensures that enrollees enjoy some minimal procedural protections regardless of the State in which they reside.

Comment: Several commenters believed that HCFA should clarify that States with separate child health programs have flexibility in setting up appeals processes to determine what appeals are submitted to whom, and do not need to use the Medicaid procedures. For example, the commenters asked for clarification that, if a State uses the health plan or another appeals body for its review process, the State can have grievances sent directly to that entity.

Response: While the use of Medicaid fair hearing procedures for a separate child health program may be efficient for some States as it may eliminate the need for two parallel, and to some extent, duplicative processes, the use of Medicaid procedures is not required in a separate child health program. States may determine the structure of their review process as long as it complies with the minimum standards of this regulation. In order to alleviate any confusion created by the language of proposed § 457.985(c), which noted that States have the option to adopt the Medicaid procedures, we removed that language from the final regulation text.

Comment: One commenter believed that HCFA should clarify that States that have implemented Medicaid expansions must provide applicants and recipients all of the Medicaid protections.

Response: To clarify, States that implement Medicaid expansions must provide applicants and enrollees all of the Medicaid protections. Subpart K only applies to separate child health programs.

Comment: One commenter was concerned about the grievance procedures proposed in the Medicaid managed care regulations. The commenter was concerned about the meaning of the term ''complaint;'' obligations to submit the decision and case file to the State agency; issues arising from the State fair hearing process; the obligation of a managed care entity to issue a notice of intended action; administrative issues regarding how the organization handles complaints and grievances; and continuation of benefits obligations pending appeal.

Response: This commenter's concerns relate to the final regulation for Medicaid managed care, and are beyond the scope of this regulation. We direct interested parties to review the Medicaid managed care final rule, once published, for issues related to Medicaid managed care. Again, subpart K only applies and relates to separate child health programs.

Comment: One commenter requested that HCFA clarify whether a State that has existing laws relating to consumer protections is able to choose its Medicaid procedures instead. A different commenter suggested that the proposed regulations could be read to suggest that HCFA anticipates that States will use both the Medicaid procedures and procedures applicable to commercial health plans. However, this commenter noted that many States do not have the same grievance rules for Medicaid and for commercial health plans, so it may be impossible for managed care entities to meet both sets of requirements. This second commenter assumed that HCFA intended that the use of Medicaid procedures and procedures applicable to commercial health plans would be alternatives, and recommended that HCFA clarify this issue.

Response: As noted above, the use of Medicaid procedures may be efficient for States, but those procedures are not required. State laws applicable to commercial plans may or may not apply to a separate child health program, depending on the provisions of the State law. We expect that States that decide to adopt Medicaid procedures for the review process in their separate child health program will thereby be meeting State law requirements applicable to commercial health plans. However, this rule only establishes core elements and minimum standards for reviews; it does not require States to adopt Medicaid review procedures.

Comment: A few commenters proposed giving States three options to comply with requirements for grievance and appeals procedures: (1) processes that comply with the State grievance and appeal procedures currently in effect for health insurance issuers; (2) the Medicaid rules, systems and procedures; or (3) the Health Carrier External Review Model Act as developed by the National Association of Insurance Commissioners (NAIC).

Response: We appreciate the suggestion on possible models. However, rather than mandating a specific, detailed model that States must follow, we elected instead to establish core elements and minimum standards that reflect the most important aspects of these and other models of patient protection, but give States flexibility over the design of their review process. States can elect to use any model as long as that model addresses each of the core elements and meets or exceeds the minimum requirements set forth by this regulation.

Comment: One commenter supported internal review by the contractor and external review by an independent agency (or the State agency) for appeals related to eligibility, premiums and benefits. Another commenter questioned HCFA's requirement for external and internal review.

Response: We appreciate the support expressed by one of these commenters and acknowledge the diverging opinions on the value of internal and external reviews. In this final regulation, we address external review only, and only with regard to adverse health services matters. Under § 457.1130(b) of this final regulation, we require that a State ensure that an enrollee has the opportunity for external review of a decision by the State or its contractor to delay, deny, reduce, suspend, or terminate health services in whole or in

part, including a determination about the type or level of services; or for failure to approve, furnish, or provide payment for health services in a timely manner. Under § 457.1150(b) we require that States must provide enrollees with the opportunity for an independent, external review that is conducted either by the State or a contractor other than the contractor responsible for the matter subject to external review. States retain the flexibility to determine whether, how, and when to require internal review of these decisions and other kinds of decisions and actions. As for decisions relating to eligibility and disenrollment for failure to pay cost sharing, as described below, a review process that meets core elements outlined in § 457.1140, and applicable standards of §§ 457.1150–1180, will meet the standards set by these regulations. We note that under §§ 457.1150(a), we require that a review of an eligibility or enrollment matter as described in § 457.1130(a), must be conducted by a person or entity who has not been directly involved in the matter under review. This could be a State agency or an independent contractor employed by the State to assist with making eligibility determinations. The State may decide to use the same review process for reviews of eligibility and health services or different process at its discretion.

Comment: One commenter believed that the grievance and appeal system must be designed to provide enrollees with a single point of entry so that, regardless of the subject matter, enrollees file their grievances or appeals with a single State entity. The entity would then be responsible for assigning it to the appropriate reviewing authority.

Response: We recognize the importance of easy and clear access to the review process. In § 457.110(b)(6), we require States to make available to potential applicants, and to provide to applicants and enrollees information on the review process. We also require States to describe the core elements of their review process in their State plans, in part to assure that the public has input into the design of the review process. A single point of entry may be an efficient way to manage the process, particularly if the State decides that different entities will be responsible for reviewing health services and eligibility decisions. However, a single point of entry for the review process is not required by this final regulation.

Comment: One commenter expressed their view that the rules lack sufficient clarity and specificity to ensure that consumers will be accorded adequate due process protections in a State that does not adopt the Medicaid procedures. Accordingly, in this commenter's view, HCFA should outline the basic requirements that must be addressed by a State if it does not choose the Medicaid system. At a minimum, this commenter suggested that these requirements should specify: (1) the content of the written notice; (2) circumstances for continued benefits; (3) processing of grievances and fair hearings including exhaustion requirements; (4) the enrollees' rights and responsibilities during the grievance and fair hearing process; (5) standards for conduct of the hearing; and (6) time frames for expedited and final resolution of grievances and appeals.

Several commenters underscored the need for due process protections in title XXI because of the lack of entitlement to benefits under the program and recommended requiring the Medicaid procedures. One commenter suggested that families need full access to an impartial review process, timely and adequate notices, opportunities to review records and evidence and examine witnesses, the right to represent themselves or to bring a representative, the right to receive a decision promptly, and the right to prompt corrective action. According to this commenter, referencing State laws without applying specific standards will be inadequate to assure equitable treatment of children because some of the laws are loose and vague on matters such as the time period within which a grievance must be resolved, who must hear the appeal, and what notice must be provided.

Another commenter considered it inappropriate to allow States with separate child health programs to use less stringent appeal procedures than required under Medicaid. In the commenter's opinion, SCHIP benefits are targeted at low-income children who, like Medicaid eligibles and recipients, have limited resources. The commenter also noted that while SCHIP is not an entitlement, constitutional due process considerations may apply and require that recipients be afforded minimal protections. If this is the case, the commenter noted that HCFA's current proposed rule may not meet those standards.

Response: We agree with these commenters about the need to set forth minimum standards for procedural protection for States with separate child health programs and provide these protections in §§ 457.1120 through 457.1190 of the final regulation. We adopted many of the commenters' suggestions in these sections of the final regulation, consistent with basic principles of due process. We did not elect to issue requirements for exhaustion of an internal review process, opting instead to require external review of health services matters as described in § 457.1130 and setting maximum time frames for the completion of external review (and internal, if available) in § 457.1160(b). It is within each State's discretion whether and in what conditions internal review will be available. The requirement is that the external review be implemented within 90 days (taking into account the medical needs of the patient). If a State chooses to establish internal review, internal and external review must be completed within that time frame.

We also left to the State's discretion enrollee responsibilities during the review process, although the regulations do set forth basic enrollee rights in § 457.1140. Many of the other protections suggested by the commenters have been addressed throughout §§ 457.1120–457.1180. In these sections, we identify basic procedural protections that are common to most review procedures and that must be provided in the context of separate child health programs. However, in the interest of preserving State flexibility, we left many of the particular design elements related to implementing the protections to the State's discretion.

Comment: One commenter noted that clarification is needed with regard to which types of decisions are subject to which grievance and appeals processes.

Response: We acknowledge the need for clarification about the scope of the requirements relating to review processes and provide it in the final regulation at § 457.1130.

Comment: One commenter noted inequity in the fact that Medicaid expansion programs receive 75 percent FMAP for grievance and appeal activities while separate child health programs are required to pay for these activities within the 10 percent limit for administrative expenditures.

Response: As the commenter indicated, section 2105(c)(2) of the Act places a limit on administrative expenditures. The costs of a review process are subject to the enhanced matching rate under SCHIP and may or may not be considered administrative costs that fall under the 10 percent administrative cap, depending on the nature of the expenditure and the method by which it is paid. While there is no cap on administrative expenditures within Medicaid, such

expenditures consume far less than 10 percent of Medicaid spending. To the extent that a State relies on preexisting review mechanisms, such as those that may be operating under the State's insurance laws, the State's employee health plan or it's Medicaid program, further efficiencies may be realized.

Comment: Several commenters noted the need to include grievance or appeal protections for providers who contract with SCHIP managed care entities or with SCHIP programs on a fee-for-service basis. In the opinion of these commenters, such protections are necessary because many of these ''safety net'' providers cannot afford to have payments withheld, delayed or denied without an expedited process to challenge the actions of the managed care entity or SCHIP program. One State did not support the requirement that providers be given a notice of appeal.

Response: We agree that States need to adopt procedures to address these concerns, but did not include in the proposed regulation or incorporate in this final regulation a requirement that States adopt procedural protections for providers involved in disputes with a State or a contractor. Providers and their advocates may work at the State level to obtain such protections, which States have the flexibility to provide.

Comment: Several commenters recommended that the regulation require that bilingual workers and linguistically appropriate materials used in application assistance, including information relating to grievances and appeals, be made available to ensure that all applicants, including those with limited English proficiency and persons with disabilities (parents and guardians with disabilities) are given notice and understand their rights concerning eligibility. Commenters recommended that the preamble explain the title VI mandate requiring linguistic access to services and give examples of how States and contracted entities can comply. Two commenters asked that both the preamble and regulations make it clear that failure to provide linguistically and culturally appropriate notices and services is grounds for filing a grievance or appeal.

Response: We addressed these comments in subpart A along with other comments on § 457.110 and § 457.130.

Comment: One commenter on § 457.365 noted that the grievance and appeal provisions depend almost entirely on the ability of families to know about and comprehend the nature of the rights available. According to this commenter, organizations upon which families rely for information should be utilized in a family-friendly manner.

Response: In § 457.110 we set forth requirements regarding the availability of accurate, easily understood, linguistically appropriate information for potential applicants, applicants, and enrollees, including information about the review process. We also encourage organizations working with enrollees to provide appropriate assistance to enrollees' families in accessing and navigating the review processes in the State. Additionally, under § 457.1140(d)(1), we require that States provide applicants and enrollees with the opportunity to represent themselves or have representatives of their choosing in the review process.

- State plan requirement § 457.1120 (proposed § 457.985(b)).

Proposed § 457.985(b) required States to establish and maintain written procedures for addressing grievances and appeals. We received many comments to subpart A noting the need for more routinized public input into the development of the State plan. In order to ensure public input into the development of the grievance and appeal procedures and ensure that each State addresses the core elements as it designs its procedures, the final regulations require a State to describe its review process in its State plan, pursuant to § 457.1120. We believe that the combination of State flexibility, minimum Federal standards, and public input will produce systems that provide necessary and appropriate procedural protections without imposing a ''one size fits all'' approach.

- Matters Subject to Review § 457.1130 (proposed §§ 457.361(c), 457.365, 457.495, 457.565, 457.970(d), 457.985(a)).

Eligibility and Enrollment Matters

In § 457.361(c), we proposed to require that States provide an applicant whose eligibility is denied or an enrollee whose enrollment is terminated with an explanation of the right to request a hearing. In proposed § 457.985(a)(1) and (2), we proposed to require that States give applicants and enrollees written notice of their right to file grievances and appeals in cases where the State takes action to deny, suspend, or terminate eligibility, or to disenroll for failure to pay cost sharing. Section 457.365 of the proposed regulation provides that a State must provide enrollees in separate child health programs with an opportunity to file grievances and appeals for denial, suspension or termination of eligibility in accordance with § 457.985. Likewise, § 457.565 of the proposed regulation provided that a State must provide enrollees in separate child health programs with the right to file grievances and appeals as specified in § 457.985 for disenrollment from the program for failure to pay cost sharing. In § 457.970(d), we proposed that a State may terminate the eligibility of an applicant or enrollee for ''good cause'' other than failure to continue to meet the requirements for eligibility. We also provided that enrollees terminated for good cause must be given a notice of the termination decision that sets forth the reasons for termination and provides a reasonable opportunity to appeal the termination decision.

Comment: One commenter indicated that since title XXI is not an entitlement, and therefore children are not entitled to receive services, States should not be required to establish a grievance procedure for children terminated for good cause.

Response: As provided by § 457.1130(a), States must provide enrollees in a separate child health program with an opportunity for a review of a termination of eligibility. The opportunity for a review is an important component of a fair and efficient system that should apply regardless of whether a State believes that it terminated coverage for good cause. Indeed, in such a situation, the purpose of the review would be to allow the enrollee an opportunity to address whether there was good cause to terminate eligibility. Reviews serve an important purpose regardless of whether the coverage provided is considered to be an entitlement. In this final regulation, we removed proposed § 457.970(d) (concerning ''good cause'') because we found it unnecessary and the comments suggested it was potentially confusing. States have the flexibility to identify any number of reasons for terminating an enrollees's eligibility that are consistent with this regulation.

Comment: A few commenters believed that denials, suspensions, and terminations of eligibility should be reviewed under a different process than the internal and external review process set out in § 457.985(b). Several commenters also questioned the appropriateness of utilizing the envisioned grievance and appeals system for decisions regarding failure to pay cost sharing and noted that disenrollment for failure to pay cost sharing should be reviewed under a different process than that set out in § 457.985. One commenter suggested that HCFA require States to use their Medicaid grievance and fair hearing process for eligibility and disenrollment determinations rather than deferring to

internal appeals or State-specific insurance practices.

Response: We agree with the comment that internal and external review consistent with State insurance law may not be the appropriate form of review for eligibility and enrollment matters, but we leave this matter to State discretion, as long as the minimum review requirements are met. A State may use the same process for reviewing eligibility and enrollment decisions as it uses to review health services decisions, or it may use different processes as long as the requirements pertaining to each type of review are met.

Comment: One commenter suggested that HCFA permit applicants and enrollees to file grievances and appeals on the grounds that eligibility determinations were limited or delayed.

Response: We agree that an enrollee should be given the opportunity for a review to address the failure to make a timely eligibility determination. Section § 457.1130(a) requires a review to address such a situation. As for the case of a limitation of eligibility, we believe that denials, reduction, or terminations of eligibility encompass and therefore require an opportunity for review of a decision to limit eligibility.

Comment: One commenter believed that HCFA should modify its regulations to allow reasonable exceptions to grievance requirements, such as when disenrollment or suspension of services results from a State exceeding its allotment.

Response: Under § 457.1130(c), we provide an exception and do not require a State to provide an opportunity for review of an adverse eligibility, enrollment, or health services matter if the sole basis for the decision is a provision in the State plan or in Federal or State law that requires an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. If a State stopped enrolling new applicants because it had spent all of its allotted funds, this would likely be a situation where applicants would not need to be granted a review of the denial of their application. Whether a review would be required would depend on whether the denial was automatic and applied broadly. For example, if a State with limited funds amended its approved State plan to enroll only new applicants with special health care needs, an opportunity for review would be required to provide denied applicants an opportunity to establish that they met the State's enrollment criteria. However, if a State exceeds its allotment and no longer wishes to operate its State plan as approved, the State could either keep the plan in place and, pursuant to the State plan, suspend operation of the program until the beginning of the next Federal fiscal year when additional funding becomes available, or request withdrawal of its State plan by submitting a State plan amendment to HCFA as described in §§ 457.60 and 457.170. Under each of these scenarios, the State would no longer be approving any new applications and as such, reviews of application denials or suspensions would not be subject to the review requirements.

Health Services Matters

In § 457.985(a)(3), we proposed to require the State to provide the right to file grievances and appeals in cases where the State or its contractors take action to ''reduce or deny services provided for in the benefit package.'' In addition, proposed § 457.495 required States to provide enrollees in a separate child health program the right to file grievances or appeals for reduction or denial of services as specified in § 457.985.

We note that the range of health services-related matters required to be subject to review under the final rule is more narrow than the range of matters included within the definition of grievance in the proposed rule.

Comment: Several commenters agreed with the inclusion of § 457.985 in the proposed rule but encouraged modification of the provision to include the right to file a grievance or appeal for the *termination* of services as well as for reduction or denial of services *in whole or in part.*

Response: We agree with this comment, and § 457.1130(b)(1) of the final rule reflects that States must ensure that an enrollee has an opportunity for external review of matters related to delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services.

Comment: A commenter suggested that HCFA should permit applicants and enrollees to file grievances and appeals on the grounds that requests for covered services were limited or delayed.

Response: We agree with the comment, and in § 457.1130(b)(2), we require States to ensure an enrollee has an opportunity for external review of a failure to approve, furnish, or provide payment for health services in a timely manner.

Comment: One commenter noted that the system of review to an independent body should resemble the Medicaid system to the extent possible, in order to ease the burden on providers and to provide continuity for families who move between programs.

Response: We recognize the importance of easing the burden on providers and on families who move between a separate child health program and Medicaid. However, we decided not to require that the external review for separate child health programs mirror the external review process required under Medicaid and to take a more flexible approach consistent with title XXI. We note that some States have chosen to adopt the Medicaid model for reviews in order to have a consistent system of review for their child health programs.

Comment: One commenter indicated that States should provide a timely appeals process that includes direct discussion between the reviewing panel, the patient's physician and the relevant specialists and, if appropriate, an external review by an independent panel of pediatricians experienced in the treatment of the patient's illness.

Response: We agree with the need for a timely process. Under § 457.1140(b), review standards must be timely in accordance with the time frames set forth under § 457.1160. However, under this final regulation, we have not prescribed the type of communication that must be allowed between the enrollee's physician and any review panel. The State has the leeway to require consultation with the enrollee's provider and/or with independent physicians, within the framework of the minimum standards established by these rules.

Comment: One commenter believed that § 457.985(d) should be deleted because the term ''complaint'' is not defined and it is not clear what type of problem constitutes a complaint that would end up outside the grievance and appeals processes. The commenter noted that it is also unclear who would be responsible for making such a determination, and what would happen should the plan decide that a consumer's grievance is really only a ''complaint,'' or vice versa. In this commenter's view, the regulation should not sanction the development or utilization of ''complaint'' systems that fall outside of the grievance and appeals process.

Response: We have deleted proposed § 457.985(d) from the regulation text because we agree that its provisions were unclear. Under the final regulation, we decided only to require

external review of the types of matters described in § 457.1130(b) and to leave States and their contractors the flexibility, within the confines of applicable law, to design review procedures to address any decisions or actions not required to be subject to review under the final regulation.

• Core Elements of Review § 457.1140

Comment: One commenter asserted that HCFA should specify the basic components of a fair hearing, that the State agency responsible for administering the separate child health program, rather than a managed care plan, should retain responsibility for eligibility and enrollment appeals, and that the preamble should encourage States to use the Medicaid fair hearing process for appeals of this kind. According to this commenter, a fair hearing requires the following components: (1) The right to an impartial hearing officer; (2) the right to review records that will be used at the hearing; (3) the right to review evidence and examine witnesses; (4) the right to represent oneself or be assisted by another; and (5) the right to obtain a timely written decision with an explanation of the reasons for the decision. One commenter specifically questioned the rationale for external review of eligibility decisions because those decisions do not require the medical judgement necessary in benefit denials.

One commenter argued that HCFA should adopt minimum standards for States that opt not to use their Medicaid fair hearing processes to ensure that: (1) Appeals and determinations are timely; (2) decisions are made by an impartial hearing officer or person; (3) hearings are held at reasonable times and places; and (4) enrollees have a right to: (a) Timely review their files and other applicable information necessary to prepare for the hearing; (b) be represented or represent oneself; and (c) present testimony and evidence.

Response: While we agree that a State agency review, such as the Medicaid hearing process, may be more appropriate for eligibility and enrollment matters than an internal and external review process developed under an insurance model for health services matters, we determined it was not appropriate to require a State agency review or the Medicaid process for separate child health programs. Instead, these final regulations establish a set of core elements that each State must address when it designates its review process.

Section § 457.1140 incorporates certain suggestions of commenters and requires that States, in conducting a review, ensure that: (a) Reviews are conducted by an impartial person or entity in accordance with § 457.1150; (b) review decisions are timely in accordance with § 457.1160; (c) review decisions are written; and (d) applicants and enrollees have an opportunity to: (1) Represent themselves or have representatives of their choosing in the review process; (2) review their files and other applicable information relevant to the review of the decision; (3) fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and (4) receive continued enrollment in accordance with § 457.1170.

Comment: Two commenters noted that § 457.361(c) establishes that notices of eligibility decisions must include information about the right of applicants to request a ''hearing.'' Proposed § 457.365, on the other hand, requires States to provide enrollees in separate child health programs with an opportunity to file ''grievances and appeals'' for denial, suspension, or termination of eligibility. These commenters expressed that the multiple reviews suggested by both these provisions of the proposed rule have the potential to create unnecessary administrative expenses for the State and to confuse consumers.

One of these commenters agreed that an applicant should receive an explanation, preferably in writing, if an application is denied. This notice is particularly important when the State uses a variety of ''helpers,'' such as community organizations or other program staff, to assist in the enrollment process. In such situations, the commenter believed that opportunities for misinformation or miscommunication arise. For Medicaid programs, the commenter noted the word ''hearing'' is used to mean the entire State fair hearing process, which is a formal and often lengthy procedure. For separate child health programs, however, a much simpler process, such as review by a senior staff member, is appropriate according to this commenter, given that there is no individual entitlement to benefits under title XXI. This commenter therefore recommended that § 457.361(c) be amended to make it clear that separate child health programs need not employ the Medicaid hearings process and that the State should provide an opportunity for review of such decisions that need not take the form of a hearing.

Response: We recognize that we may have created confusion in using different terminology in §§ 457.361(c) and 457.365. We therefore clarified the review process that will be applicable to adverse eligibility matters in § 457.1140 of the final regulation.

We appreciate the commenter's concern that certain enrollee protections may create an additional administrative expense for some States. However, on balance, the importance of ensuring an enrollee's basic right to a fair and efficient decision regarding eligibility for health benefits coverage justifies the administrative expenses that may be incurred. We note, furthermore, that these final regulations accord States broad flexibility to design review processes that operate efficiently without undue administrative costs. We also appreciate the support for the requirement that notice must be provided in writing.

As for the concerns about the mechanics of the review process, States with separate child health programs do not have to use the Medicaid fair hearing process as the mechanism for review of adverse eligibility and enrollment matters. While an opportunity for review of such matters is required, we left it to the States' discretion to develop the details of the review process for their separate programs, provided the process meets the minimum guidelines set forth in §§ 457.1140, 457.1150(a), 457.1160(a), 457.1170, and 457.1180.

Comment: One commenter asked that HCFA clarify what kinds of procedures will be necessary if a State does not elect to use its Medicaid program or does not have existing State law. One commenter expressed their view that the language of proposed § 457.985 could be interpreted to mean that States without existing State laws requiring internal and external review procedures need not establish any procedures for children enrolled in SCHIP. One commenter stated their view that a choice between Medicaid and State insurance practices is appropriate for issues other than eligibility and disenrollment determinations.

Response: We agree with the comment that our proposed rule could leave children in some States without access to a review process. Since State law varies and some States do not have applicable State laws, in order to assure some minimum standard of protections for all children, we elected to adopt in § 457.1140 minimum standards for conducting reviews of matters identified in § 457.1130. In addition, under §§ 457.1130(b) and 457.1150(b) of this final regulation, a State is required to ensure that enrollees have the opportunity for an external review of certain health services matters,

regardless of whether external review is required under existing State law. Internal reviews are not required by these regulations.

• Impartial Review § 457.1150 (proposed § 457.985(b)).

We proposed under § 457.985(d) that States must establish and maintain written procedures for addressing grievances and appeal requests, including processes for internal review by the contractor and external review by an independent entity or the State agency. We proposed that these procedures must comply with State-specific grievance and appeal requirements currently in effect for health insurance issuers (as defined in section 2791(b) of the Public Health Service Act) in the State.

Comment: One commenter recommended the language at § 457.985(b) be amended to read ''* * * process for internal review by the contractor and independent external review by the State agency * * *.'' This commenter noted it has established a strong independent review process through the State insurance agency. The commenter said that the term ''independent entity'' when used to describe an external review can be interpreted to mean an organization separate from the health plan, but chosen by the plan to do the reviews. The commenter noted that such an arrangement is a clear conflict of interest and indicated that the independence of reviewers can be best assured if the review goes through a neutral State agency. The commenter did not support the NAIC's Health Carrier External Review Model Act.

Response: We appreciate the concern related to the independence of external reviews and have made some modifications to clarify and emphasize the need for an impartial review. To afford States the greatest flexibility in how they implement their external review process, we did not change the language to allow only for external review by a State agency. Consistent with applicable State law, States may choose the entity that will provide external review.

However, under § 457.1150(b), with respect to an external review of health services matters, we did specify that the external review must be independent and conducted by the State or a contractor other than the contractor responsible for the matter subject to external review. To the extent that a State relies on a contractor to conduct such reviews, we expect that States will closely monitor the review process to assure that enrollees are in fact receiving an independent review of their case. We also encourage community organizations and advocates to work closely with families to assist them in navigating the process and to assist the State in identifying issues related to impartiality or conflicts of interest if they arise. We would also like to note that in the review of eligibility and enrollment matters, we require under § 457.1150(a) that a review must be conducted by an impartial person or entity who has not been directly involved in the matter under review.

Comment: One commenter expressed the view that the automatic placement of adverse decisions on the docket of a State fair hearing system is critical to ensuring that the rights of enrollees are fully vindicated, given that the State hearing system is the first time the enrollees receive an independent review. This commenter believed the burden placed on the fair hearing system would not outweigh the Constitutional deficiency of not requiring an automatic filing for a fair hearing after an adverse decision by a non-impartial decision maker. This commenter said that due process concerns are significant, and that enrollees may not truly comprehend that they have a right to an external review despite the best efforts at notice on the part of a State/contractor and assuming they understood the notice of their rights. The commenter believed that automatic referral would reduce these problems, improve public perception about health care decisions given the review by an impartial decision maker, and improve the overall quality of care by encouraging correct treatment decisions at the outset.

The commenter noted that the number of cases proceeding through the State fair hearing process, even with automatic referral, may not be substantial or costly. According to the commenter, in Medicare where automatic referral occurs, the cost is generally less than $300 per case. In 1997, automatic referral resulted in only 1.65 cases per 1000 managed care enrolles. Yet, this commenter stated, access to an outside impartial review is clearly significant for enrollees. The commenter pointed to a Kaiser Family Foundation study on State external review laws that found almost 50 percent of cases considered through an external appeals review overturned the managed care organization's initial decisions. The commenter noted that while States have financial concerns in maintaining a streamlined external review process, such concerns should not overrule an enrollee's right to due process.

Response: As noted above, States do not need to use the State fair hearing process as the independent external review process required under §§ 457.1130(b) and 457.1150(b). External review can be done either by a State agency or a contractor other than the contractor responsible for the matter subject to external review. While we appreciate the commenter's concerns, we elected not to require States with separate child health programs to ensure the automatic referral of adverse decisions to external review. We did, however, adopt minimum procedural protections related to the right to an independent external review in certain situations, consistent with the requirements of due process.

We acknowledge the important information contained within the study cited by the commenter relating to the minimal administrative cost of automatic referral. Given the low cost of such a process, and the added protections and accountability it can provide in some circumstances, we encourage States to consider this option carefully when establishing their review process.

• Timeframes § 457.1160 (proposed §§ 457.361(c), 457.985(b) and 457.995(g)(2)).

In proposed § 457.985(b) and § 457.995(g), respectively, we required that ''resolution of grievances and appeal requests will be completed within a reasonable amount of time'' and that ''grievances and appeals must be conducted and resolved in a timely manner that is consistent with the standard health insurance practices in the State in accordance with § 457.985.'' In proposed § 457.361(c), we provided that ''the State must send each applicant a written notice of the decision on the application and, if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time.''

Comment: Several commenters noted that the regulation should require that grievances and appeals be decided in a timely fashion. Several commenters asserted that if HCFA decides to maintain its proposed policy on grievances and appeals, strict minimal timelines should be incorporated to ensure that grievances and appeals are conducted in an expedited manner. A different commenter, representing providers, noted that it saw no reason why providers should not be expected to respond within seven days to a request for treatment. That commenter noted that if a State/contractor denied such a request, an enrollee would not receive any new benefits until the final

resolution of the grievance process. A State/contractor could request an extension if it could show the extension would be in the enrollee's best interest. The commenter also believed that HCFA should establish minimum requirements for an expedited procedure to meet the needs of enrollees with severe medical conditions.

This commenter also suggested a requirement of 14 days for a response to a standard grievance. Two commenters acknowledged that suggested time frames are different from the 30 day time frames in Medicare+Choice and Medicaid managed care, but argued that SCHIP enrollees do not have the opportunity to get services elsewhere while they are waiting for the appeal to be resolved. One commenter also noted that when Medicaid and SCHIP individuals are denied treatment, they often have no other recourse except the proposed grievance process. They recommended that HCFA reduce the standard resolution time frame in Medicaid managed care from 30 to 14 days. A different commenter recommended providing for an accelerated process where there is an initial denial of services that poses the risk of serious medical harm.

Several commenters recommended HCFA define maximum time frames, and one commenter recommended HCFA define a ''reasonable'' time period and indicate what maximum time frame would still meet the ''reasonable'' requirement. This second commenter also believed that a lengthy grievance process might be held to violate an enrollee's due process rights. The commenter recommended a maximum time frame of fourteen days for responding to a standard grievance, which may be to review a provider's decision not to provide requested items or services, or to review a provider's decision to deny, suspend, or terminate eligibility, reduce or deny benefits, or disenroll the enrollee for failure to pay cost sharing. The commenter noted that, in many cases, the State/contractor will have an established policy and will not need the full fourteen days. This commenter also noted that even in cases which involve an assessment of an individual's condition, fourteen days is ample time. The commenter advocated that States be allowed to set a time frame of less than fourteen days. The commenter noted that a State/subcontractor does not necessarily save money by delaying resolution of a grievance, because the State remains financially responsible for the care and may have to reimburse the family for expenses incurred prior to enrollment. In certain cases, it might cost the State/subcontractor more to delay treatment because the treatment ultimately required might cost more than the initial requested treatment.

Response: As reflected in the proposed regulation, we agree that a review process should be completed in a timely fashion and, as reflected in the final regulation, that there is a need for minimum timeliness standards. As in the proposed regulation, in § 457.340(c) of this final regulation, we prescribed maximum time frames for eligibility determinations. In this final regulation, we also separately address the timeliness of review of eligibility and enrollment matters, and the timeliness of review of adverse health services matters. Under § 457.1130(a), a State must ensure that an applicant or enrollee has an opportunity for review of a: (1) denial of eligibility; (2) failure to make a timely determination of eligibility; or (3) suspension or termination of enrollment, including disenrollment for failure to pay cost sharing. Under § 457.1160(a), the State must complete the review of the matters described in § 457.1130(a) within a reasonable amount of time. In order to ensure that delays in the review process do not cause a gap in coverage, under § 457.1170, States are required to provide an opportunity for the continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing. We also require the State to consider the need for expedited review when there is an immediate need for health services. Under § 457.1120 we require States to describe these time frames in their State plans.

In light of concern about the time frames for review of health services matters, we specified a time standard for the resolution of external reviews (and any internal review if available), including expedited time frames, in § 457.1160(b). Health services matters subject to review include: (1) delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; or (2) failure to approve, furnish, or provide payment for health services in a timely manner. Reviews must be completed in accordance with the medical needs of the patient. Under the standard time frame, a State must ensure that external review of a decision as described in § 457.1150(b) is completed within 90 calendar days of the date an enrollee initially requests external review (or an internal review if available) of the decision. Under the expedited time frame, a State must ensure that internal review (if available), or external review as required by § 457.1150(b), is completed within 72 hours of the time an enrollee initially requests a review if the enrollee's physician determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has access to internal and external review, then each level of review must be completed within 72 hours (for a possible total of 144 hours). The State must provide an extension to the 72-hour period of up to 14 days if the enrollee requests such an extension. This provision for an expedited time frame reflects our agreement with the comments calling for an accelerated process if the passage of the standard time allowed for the process poses serious harm to the enrollee.

Comment: One commenter recommended that in order to ensure an enrollee's rights to obtain timely medical care, both the internal grievance process and the State fair hearing process should conclude within 90 days. They noted that current State fair hearing regulations require a State to complete the fair hearing within 90 days from the request for the hearing.

This commenter also stated the proposed regulations did not provide guidance on what happens if a State/contractor fails to meet its grievance and appeals procedures and recommended HCFA establish minimum standards to address noncompliance. The commenter said that even with standard health insurance practices, there is no guarantee that a State/contractor will comply in a timely fashion. The commenter recommended the approach of the Medicare+Choice regulations that provide that an managed care organization's failure to meet initial determination and reconsideration time frames is automatically considered an adverse decision that is referred to the next level of review. This commenter advocated that HCFA adopt this policy in the SCHIP regulations as well. The commenter believed this position, coupled with minimum time frames, would best protect enrollees' rights without causing undue hardships on providers.

This commenter also recommended that HCFA should grant States the authority to impose monetary fines upon participating contractors for failure to meet time frames as a means to enforce compliance. The commenter recommended amending § 457.935 to include language requiring States that contract with participating contractors to impose sanctions if the State determines that a participating

contractor fails to provide medically necessary services that the participating contractor is required to provide, or fails to meet specified time frames.

Response: Under § 457.1160(b)(1), we defined the standard time frame for the review of a health services matter. A State must ensure that external review, as described in § 457.1150(b), is completed within 90 calendar days of the date an enrollee requests external review (or internal review if available). We expect that an enrollee will be provided notice of the outcome of the review within the 90-day time frame. As described above, the final regulations provide an opportunity for expedited review, under § 457.1160(b)(2).

We do not see a need to create further compliance standards or enforcement mechanisms beyond those that have been already implemented pursuant to section 2106(d)(2) of the Act. This provision requires States to comply with the requirements under title XXI and allows HCFA to withhold funds from States in the case of substantial noncompliance with such requirements. It is within the State's discretion to determine whether to include in contracts monetary fines for failure to meet time frames as a means to enforce compliance with required time frames. States are, of course, required to administer their programs in accordance with the law and their State plans. At a minimum, therefore, States are responsible for monitoring the conduct of their contractors and ensuring that their conduct fully complies with these regulations and the State plan.

Comment: One commenter noted that the regulations do not make clear the relationship between the internal and external review processes. In most instances, State law requires exhaustion of the internal review process (as does the NAIC model) before a consumer can move to the external review. However, a number of States also include timelines and exceptions (for example, when the harm has already occurred) to ensure that this does not impede the process unnecessarily, and the commenter recommended that HCFA do the same. Another commenter expressed that HCFA should prohibit States from requiring exhaustion of internal plan processes. If HCFA does not prohibit such a requirement, according to this commenter, it must include adequate safeguards so that plans do not benefit from delay at the enrollee's expense. Specifically, HCFA should require that States set strict timetables for review and determination, assure aid continuing pending a determination, and provide for expedited review when the failure to authorize a required level of treatment or to provide or continue a service jeopardizes the enrollee's health.

Another commenter noted that some States may require an enrollee to exhaust a plan's internal grievance procedures before allowing access to the State fair hearing process and believed these State practices may violate enrollee's due process rights. The commenter requested that we ensure that enrollees not be required to exhaust internal grievance procedures before accessing the State fair hearing process. The commenter was concerned that the internal grievance process does not provide impartial review. They noted that even under the proposed Medicaid managed care regulations, the individual conducting the internal review, while not familiar with the case file, is employed by the plan provider. According to this commenter, this individual has an inherent pecuniary interest to resolve the grievance in favor of the State/contractor. Because the enrollee is effectively denied benefits until the process is complete, States/contractors have little incentive to resolve the grievances quickly. The commenter argued that if the enrollee is forced to exhaust the internal grievance process, the enrollee would be deprived of due process. The commenter recommended HCFA amend § 457.985(b) to permit the enrollee to request a State fair hearing on a grievance at any time.

Response: It should be noted that the State fair hearing process is the process for external review under Medicaid managed care. While States have the option to use the Medicaid fair hearing process to satisfy the requirement for external review under this regulation, we do not require this process for separate child health programs. We also left to States the discretion to decide whether plans should be required to conduct an internal review and whether, if they do so, they should require exhaustion of internal plan processes before an enrollee could pursue an external review. Nonetheless, we believe it is important for enrollees to have certain minimum procedural protections consistent with due process and have therefore adopted minimum requirements and time frames for reviews. Under §§ 457.1130(b) and 457.1150(b), States must provide enrollees access to an external review of certain health services matters. Pursuant to § 457.1150(b), review decisions must be independent and made by the State or a contractor other than the contractor responsible for the matter subject to external review. While a State may require an enrollee to request and pursue an internal review, any procedures developed by the State or its contractors relating to internal review cannot interfere with the enrollee's right to complete the external review within 90 days from the date a review (either internal or external) is requested.

- Continuation of Enrollment § 457.1170 (Proposed § 457.985(c)).

We received a number of comments urging us to require continuation of enrollment pending completion of the review.

Comment: Several commenters were particularly concerned that children receiving benefits under separate child health programs may be as poor as those who receive Medicaid in other States, and believed that States should therefore be required to continue assistance at pre-termination levels until an impartial review of a child's case is completed. Multiple commenters argued that even though the SCHIP statute does not include the same entitlement as Medicaid, constitutional due process may require minimal protections that are not included in the proposed rule. A few commenters underscored the need for due process protections in title XXI because of the lack of entitlement to benefits under the program and recommended the Medicaid procedures. Other commenters echoed the specific suggestion that there be circumstances in which benefits continue for current recipients pending appeal.

One commenter specifically recommended that continuation of services pending appeal should occur in circumstances where termination or reduction of services poses serious medical harm and to provide for an accelerated process where there is an initial denial of services that pose such harm. Two commenters noted that continuation of benefits is especially important for enrollees terminated for failure to pay cost sharing or other financial contributions, which do not relate to an enrollee's actual eligibility for benefits. These commenters recommended that HCFA require that enrollees must affirmatively request termination of benefits. One commenter recommended the language at § 457.985 be amended by adding: ''Unless an enrollee affirmatively requests that items or services not be continued, the State/contractor must continue the enrollee's benefits until the issuance of the final grievance decision or State fair hearing decision.''

Response: We appreciate the commenters' concerns about the need to protect children enrolled in separate child health programs who have very limited incomes and whose families have little or no ability to pay for costly but necessary health services, and we

have adopted provisions related to continuation of enrollment, as described below.

Section § 457.1170 requires States to ensure the opportunity for continuation of enrollment pending review of termination or suspension of enrollment, including a decision to disenroll for failure to pay cost sharing. A State may limit the time period during which such coverage is provided by arranging for a prompt review of the eligibility or enrollment matter. However, not all such matters are subject to the continuation of coverage requirement; under § 457.1130(c), a State is not required to provide an opportunity for review of such a matter if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances. Therefore, if the situation is such that the State is not required to provide an opportunity for review according to this regulation, then the State does not have to provide the opportunity for continuation of enrollment. We also note that the costs of providing continued benefits are not administrative costs subject to the 10 percent cap, regardless of the outcome of the review. With respect to disenrollment due to failure to pay cost sharing, we have added a provision in § 457.570(b) to ensure that the disenrollment process afford an enrollee the opportunity to show that the enrollee's family income has declined prior to disenrollment for nonpayment of cost-sharing charges. Finally, we note that services need not be continued pending a review of a health services matter, although, as described above, expedited review processes must be available when the physician or provider determines that the enrollee's life or health or ability to function will be jeopardized.

• Notice § 457.1180 (proposed §§ 457.361(c), 457.902, 457.985(a), and 457.995(g)).

In the preamble to the proposed regulation at § 457.985, we stated that a State should make available to families of targeted low-income children information about complaint, grievance, and fair hearing procedures. We proposed to require that the State and its ''participating providers'' give applicants and enrollees written notice of their right to file grievances and appeals. In proposed § 457.361(c), we required that ''the State must send each applicant a written notice of the decision on the application and, if eligibility is denied or terminated, the specific reasons or reasons for the action and an explanation of the right to request a hearing within a reasonable amount of time.''

Comment: A commenter on § 457.340 and § 457.361 expressed strong support for the inclusion of rules setting minimum standards for procedural fairness, including the basic due process protections of opportunity to apply without delay, assistance in completing applications, required notices, and timely eligibility decisions. This commenter noted that notice is a basic due process right required by the U.S. Constitution under well-settled law whenever a citizen is denied a public benefit, and that the rules should specify that notice must be timely. The commenter also recommended that for current recipients, notice of an adverse action should be in advance of the action. In the commenter's view, the notice should inform people of the right to be accompanied by a representative as well as the right to appeal.

Another commenter on § 457.340 suggested that rules should specify that notice of denial or adverse action must be timely and in advance of adverse action for current benefits, with benefits continuing through an appeal process, should an appeal be initiated. In this commenter's view, notice should be required to be timely and include information regarding the right to appeal and to be accompanied to the hearing by a representative.

Response: We appreciate the support for these standards, and the effort to establish rules that are consistent with due process requirements. We agree that notice should be timely and have added this to the language at § 457.1180. As in the proposed regulation, the final regulation sets forth maximum time frames for eligibility determinations in § 457.340(c). Additionally, in the case of redetermination of eligibility, under § 457.340(d), the regulations require that in the case of a suspension or termination of eligibility, the State must provide sufficient and timely notice to enable the child's parent or caretaker to take any appropriate actions that may be required to ensure ongoing coverage. For example, if continued enrollment pending a review is allowed when a review is requested before enrollment is scheduled to end, notice of the action and the opportunity for review must be provided to the family with enough advance notice to allow the family to request the review and to keep their child enrolled pending review. Under § 457.1160(a), a State must complete review of an eligibility or enrollment matter within a reasonable amount of time. In setting time frames, the State must consider the need for expedited decisions when there is an immediate need for health services. Additionally, under § 457.1140(d)(2) we require that applicants and enrollees have a right to timely review of their files and other applicable information relevant to the review of the decision. Under this final regulation, however, while States have discretion to determine the precise timing of the notices in light of their own administrative needs, the notice of the outcome of the review must be delivered within the prescribed overall time frames for review.

We addressed the issue of notice in § 457.1180, in which we required States to ensure that applicants and enrollees are provided timely written notice of any determinations required to be subject to review under § 457.1130 that includes the reasons for the determination; an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, and the manner in which a review can be requested; and the circumstances under which enrollment may continue pending review. Section § 457.340(d) cross references the notice requirements of § 457.1180. Under § 457.1140(d)(1) States must ensure that applicants and enrollees have an opportunity to represent themselves or have representatives of their choosing in the review process. As for continuation of enrollment, the regulations require States under § 457.1170 to continue enrollment pending the completion of a review of a suspension or termination of enrollment including a decision to disenroll for failure to pay cost sharing.

Comment: One commenter requested clarification on the relationship of § 457.361(c) to the requirement in § 457.360(c). This commenter expressed a belief that every family should be notified of the status of each child's application and whether: (1) the application for enrollment in the separate child health program has been approved; (2) the application has been referred to Medicaid; or (3) the child had been found ineligible for both programs.

Response: The State must provide written notice of any determination of eligibility under §§ 457.340(d) and 457.1180. So, if the State determines that an applicant is ineligible for coverage under its separate child health program, the State must provide written notice of that determination. If the application is a joint Medicaid/SCHIP application, a State would then need to

comply with Medicaid requirements in providing notice about an applicants eligibility for Medicaid. In the case of termination or suspension of eligibility, under § 457.340(d), the regulations require that the State must provide sufficient notice to enable the child's parent or caretaker to take any appropriate actions that may be required to ensure ongoing coverage.

Comment: One commenter suggested that HCFA limit requirements that providers furnish notice to enrollees. According to this commenter, some States permit treating providers and managed care plans to provide SCHIP applications and perform direct marketing activities, but some do not. In this commenter's view, providers in States that do not allow such involvement would have no opportunity to provide applicants with notices. This commenter also suggested that HCFA not require treating providers who serve SCHIP enrollees under a managed care contract to provide notice to enrollees. This commenter suggested that this would be more appropriately done by the managed care plan in the member information materials. Yet another commenter strongly supported the language in § 457.985(a) requiring that participating providers, in addition to States, provide applicants and enrollees written notice of their right to file grievances. This commenter argued that it is important that applicants and enrollees have access to information about their grievance and appeal rights at the points of direct contact—which is most often the provider.

Response: In § 457.1180, we specified the general content of the notice but left States the flexibility to determine who should provide the notice. We do not consider general statements of procedure in initial member information materials sufficient notice of the review process available for a particular determination.

Comment: One commenter noted that enrollees should be informed of their right to appeal any adverse decision to an independent body.

Response: We agree with the need for enrollee notification. Section 457.1180 requires timely notice of determinations subject to the review process specified in this regulation, including matters subject to external review by an independent entity.

• Application of Review Procedures where States Offer Premium Assistance for Group Health Plans § 457.1190.

We note that under this final rule we use the term ''premium assistance program'' instead of ''employer-sponsored insurance model'' to describe a situation where a State pays part or all of the premiums for an enrollee or enrollees' group health insurance coverage or coverage under a group health plan. Our responses to comments referring to ''employer-sponsored insurance models'' reflect this change in terminology.

Comment: One commenter noted that for coverage provided under a premium assistance program, the State does not contract for services and is not in a position to dictate compliance with requirements included in § 457.985.

Response: We acknowledge that States' SCHIP programs do not have direct authority over group health plans that may be providing coverage under premium assistance programs. At the same time, there is no basis for providing children fewer procedural protections because they may be enrolled in a premium assistance program under SCHIP. In order to balance these concerns, the regulations provide States flexibility so that they may offer premium assistance through plans that do not meet the review standards set out in these regulations, as long as families are not required to enroll their children in these plans. Under § 457.1190, a State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage through its direct coverage plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

Comment: One State expressed concern that the level of detail of the CBRR provisions in the proposed regulation inhibits States from developing effective premium payment systems for premium assistance programs. Another commenter noted that under premium assistance programs, there is no contractual mechanism through which to enforce requirements, given that the employer, not the State, contracts with the health plan. This commenter said that requiring States to apply these requirements under such a model will mean that employer plans will never qualify for premium assistance. This commenter assumed that HCFA did not intend these requirements to apply to premium assistance programs, and recommended that HCFA clarify its position.

Response: While we appreciate the commenters' concern, States must comply with the requirements of this regulation regardless of whether coverage is provided through a group health plan. Under title XXI, the standards and protections apply to all children receiving SCHIP coverage, including children receiving SCHIP-funded coverage through group health plans. We do recognize that States do not have direct contractual relationships with premium assistance programs and accounted for this constraint in § 457.1190.

K. Expanded Coverage of Children Under Medicaid and Medicaid Coordination

The proposed regulations discussed in this subsection are changes to Medicaid regulations found in parts 433 and 435. These rules apply to Medicaid only.

Section 2101 of the Act requires that States coordinate child health assistance under title XXI with other sources of health benefits coverage for children. Section 2102(b)(3)(B) of the Act requires that children found through the SCHIP screening process to be potentially eligible for Medicaid under the State's Medicaid plan shall be enrolled for such assistance.

Section 4911 of the BBA, amended by section 162 of the DC Appropriations Act, Public Law 105–100, enacted on November 19, 1997, established a new optional categorically-needy eligibility group known as ''optional targeted low-income children.'' The law provides for an enhanced Federal matching rate for Medicaid services provided to children eligible under this group. The BBA also provides for States to receive this enhanced Federal matching rate for services to children who meet the definition of ''optional targeted low-income children'' and whom the State covers by expanding an existing Medicaid eligibility group (for example, poverty-related children). ''SCHIP'' itself is not a new or separate Medicaid eligibility group. A State that implements a Medicaid expansion program under SCHIP, may expand eligibility to the new optional Medicaid eligibility group just mentioned, expand eligibility to optional targeted low-income children through expanding an existing Medicaid eligibility group, or implement a combination of the two options. We note that Medicaid expansion programs are subject to all the rules and requirements set forth in title XIX of the Act and its implementing regulations, and the State Medicaid plan. Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide Medicaid services to children during a period of presumptive eligibility.

In addition to modifications to the proposed regulations made in response

to the comments discussed below, we have amended part 436 of this subchapter to reflect the changes made by the BBA to eligibility for Medicaid in Guam, Puerto Rico and the Virgin Islands. The changes made to part 436 by these regulations mirror those made to part 435, governing Medicaid eligibility in the States, District of Columbia, the Northern Mariana Islands and American Samoa. Specifically, new § 436.3 corresponds to new § 435.4; modifications to §§ 436.229, 436.1001 and 436.1002 correspond to the modifications made to §§ 435.229, 435.1001 and 435.1002; and new §§ 436.1100–1102 correspond to new §§ 435.1100–1102. Our failure to amend part 436 in the proposed rules was an oversight. There are no distinctions in policy or requirements with respect to the regulations pertaining to the States, District of Columbia, the Northern Mariana Islands and American Samoa versus those pertaining to Guam, Puerto Rico and the Virgin Islands. And any changes made to the proposed rules pertaining to expanded coverage of children under Medicaid and Medicaid coordination in these final regulations are also reflected in the amendments to part 436. We received a number of general comments on this subpart and one comment relating to the screen and enroll requirements set forth in subpart C which is relevant to this section. We will address these comments below.

1. General Comments

Comment: With respect to the screen and enrollment requirements of section 2102(b)(3)(B) of the Act, two commenters recommended that the regulations require that, even if a separate application for a separate child health program (as opposed to a joint application with Medicaid) is used, the application form and any supporting verification must be transmitted to the appropriate Medicaid office for processing without further action by the applicant to initiate a Medicaid application. One commenter recommended that if an applicant for a separate child health program, who has been determined potentially eligible for Medicaid, is to be required to take any additional steps in order to apply for Medicaid, the Medicaid agency must inform the family of the action required.

Response: The obligations of the State agency or contractor responsible for determining eligibility for a separate child health program with respect to the requirement that children screened potentially eligible for Medicaid be enrolled in that program are discussed in the preamble to subpart C and are set forth in § 457.350 of the final regulations.

We have added a new § 431.636 to clarify the obligations of the State Medicaid agency with respect to the screen-and-enroll requirement. Specifically, we have added this section to require that State Medicaid agencies adopt procedures to complete the Medicaid application process for, and facilitate the enrollment of, children for whom the Medicaid application and enrollment process has been initiated pursuant to § 457.350(h)(2) in subpart C of these regulations. Such procedures shall ensure (1) that the Medicaid application is processed in accordance with the regulations governing eligibility for Medicaid in the States and District of Columbia, 42 CFR part 435 or the regulations governing Medicaid eligibility in Guam, Puerto Rico and the Virgin Islands, 42 CFR part 436, as appropriate; and (2) that the applicant is not required to provide any information or documentation that has been provided to the State agency or contractor responsible for determining eligibility under the State's separate child health program and forwarded by such agency or contractor to the Medicaid agency on behalf of the child pursuant to § 457.350(h)(2) of this subchapter.

When a State Medicaid agency receives an application—either a joint SCHIP-Medicaid application or separate Medicaid application—for a child screened potentially eligible for Medicaid, the application must be processed in accordance with title XIX, Medicaid regulations, and the State plan. If the Medicaid agency has all the information it needs to process the Medicaid application, no further follow-up is needed until the State is ready to make a final eligibility determination. If additional information is needed, the agency must contact the family and explain what is needed to complete the Medicaid application process.

If a separate application is used, the State Medicaid agency should promptly follow up with the family as soon as it receives information about the child. If the family has not already completed a Medicaid application, the Medicaid agency should provide the family with an appropriate application and inform the family about any additional steps that must be taken or additional information which must be provided in order to complete the Medicaid application process.

Comment: We received a number of comments urging HCFA to seek statutory changes expressly authorizing more flexibility for States. The suggested changes include allowing States more flexibility under presumptive eligibility and a longer period of presumptive eligibility, and giving States the option of establishing their own filing unit rules by eliminating the prohibition on deeming income from anyone other than from a parent to a child or a spouse to a spouse.

Response: We will take these suggestions into consideration in developing future legislative proposals.

Comment: One commenter also suggested that States be allowed to ''outsource'' (privatize) Medicaid eligibility determinations.

Response: We have previously considered requests by States to privatize Medicaid eligibility determinations. Medicaid policy requires that most activities included in the eligibility determination process be performed by employees of a public agency. Therefore, we do not have the discretion to allow States to ''out source'' Medicaid eligibility determinations.

Comment: One commenter indicated that the regulations should clarify that, if a State chooses to provide continuous eligibility under section 1902(e) of the Social Security Act, as added by section 4731 of the BBA, it must provide continuous eligibility for all children who are eligible for Medicaid.

Response: These regulations do not address changes made by the BBA that are not directly related to title XXI. A separate Notice of Proposed Rulemaking will be published addressing other changes made by the BBA to the Medicaid program.

Comment: One commenter noted that, for new eligibility groups, States often have no eligibility determination experience and may be reluctant to ease the documentation and verification requirements for fear of increasing the error rate under the Medicaid eligibility quality control (MEQC). Two organizations supported waiving MEQC errors for new eligibility groups created by PRWORA, which we explained in the preamble to the proposed rule we would be willing to do. One State asked if the MEQC waiver of errors extended to the section 1931 group or to child-only groups.

Response: Section 1903(u) of the Act, which provides the statutory basis for MEQC, does not give HCFA the authority to grant a grace period for eligibility errors. However, the statute does provide that a State can request a waiver of a Federal financial disallowance relating to eligibility errors on the basis that it made a good faith effort to meet the 3-percent error rate limit. Implementing regulations at 42 CFR 431.865 include sudden and

unanticipated workload changes that result from changes in Federal law as an example of circumstances under which HCFA may find that a State made a good faith effort. Under this authority, we have offered in the past to waive errors in cases of pregnant women and infants that occurred during the first 6 months in which States were implementing a new Federal law mandating coverage of these groups (the Medicare Catastrophic Coverage Act of 1988). Our intent in offering this waiver was to encourage States to expand coverage to pregnant women and infants without the concern of fiscal penalties. It also allowed States time to develop the experience necessary to accurately determine Medicaid eligibility for these new groups.

We recognize that the sweeping changes in law brought by welfare reform and title XXI presented similar opportunities as well as many challenges to States. The PRWORA of 1996 established a new eligibility category for families with children, which is not linked to welfare. The BBA of 1997 established a new coverage group for children and established an enhanced match rate to encourage expanded coverage of children under this new group or other existing Medicaid groups. HCFA has encouraged States to take advantage of the title XXI funds to expand coverage for children, and we have encouraged States to simplify their enrollment procedures to reduce barriers to participation for all Medicaid-eligible children and their families. As we explained in the preamble to the proposed rule we would waive MEQC eligibility errors attributable to the coverage of these new and expanded groups of children and families. Our intent is to give States the opportunity to gain experience in making accurate eligibility determinations for these newly covered children without relying on lengthy applications or requiring excessive eligibility verification requirements due to State concern with fiscal penalties.

Although we are making MEQC waivers available, States are unlikely to face MEQC fiscal penalties. States have maintained a national error rate below 2-percent for over ten years. In addition, welfare reform implementation problems have resulted in eligible children and families being denied or terminated from Medicaid rather than ineligible children and families being enrolled in Medicaid. MEQC errors arise when a State makes erroneous payments. There are likely very few cases in which such erroneous payments have been made due to section 1931 implementation.

Finally, we have encouraged States to develop alternative MEQC programs because this option can be a particularly effective means of focusing on error-prone areas. Thirty-one States are currently operating alternative MEQC programs either as pilots or as part of a section 1115 waiver (most since 1994). For the duration of the pilot or section 1115 waiver, the error rates for these States are frozen at below 3 percent, and the States are not subject to disallowances.

In terms of the scope of the waiver, we agree with the comment that any waiver should apply to the section 1931 group as well as other groups pertaining to children. Therefore, we have determined that we should grant a MEQC waiver for eligibility errors directly attributable to the implementation of: (1) coverage for children and families determined eligible after October 1, 1996 for Medicaid under section 1931 or section 1925 of the Act; (2) coverage for children determined eligible after October 1, 1997 for Medicaid under the optional group of targeted low-income children under age 19 (or reasonable groups of these children) who are otherwise ineligible for Medicaid, have a family income below a certain State-specified level and have no health insurance (see section 1902(a)(10)(A)(ii) of the Act); and (3) coverage of children determined or redetermined eligible for Medicaid after October 1, 1997 whose disabled status is protected under section 4913 of the BBA. This waiver does not apply to children covered under separate child health programs because the MEQC process does not apply to such programs.

We are limiting the waivers to one year beginning with the publication date of this final rule rather than the first year of implementation of the legislation as we did previously with new coverage of pregnant women and infants. In recent months, we have learned that many States still need to adapt their systems to assure that children eligible for Medicaid under section 1931 receive Medicaid. Thus, at this point, limiting the waivers to one year after implementation of the statute would not accomplish the intended purpose. Since many States are still expanding coverage to children and are adopting new approaches to simplify their eligibility and redetermination procedures, waivers effective for one year following the promulgation of these regulations should enable States to finish updating their systems to ensure effective implementation of section 1931 eligibility without incurring financial penalties as they do so. The incidence of erroneous Medicaid denials and terminations should diminish as States gain experience, and that MEQC waivers should encourage States to move quickly to make the changes necessary to determine eligibility consistent with the requirements of the law.

Because the regulations currently provide the basis for waiver requests and the good faith waiver process is administrative in nature, it is not necessary to amend regulations at 42 CFR 431.865 to include this specific waiver exclusion. In the unlikely event that a State experiences an error rate above 3 percent over the next year, we will provide that State with instructions for applying for a good faith waiver.

Comment: One commenter expressed strong support for the conclusion that all Medicaid rules, including those related to EPSDT, apply to Medicaid expansion programs.

Response: We appreciate the support. A State that expands eligibility for children under Medicaid must apply all the title XIX rules to the expansion population including children for whom the State receives enhanced FMAP at the title XXI rate.

2. Disallowance of Federal Financial Participation for Erroneous State Payments (§ 431.865)

We proposed to amend § 431.865(b)to exclude from the definition of ''erroneous payment'' payments made for care and services provided to children during a period of presumptive eligibility. We received no comments on this section and are implementing it as proposed. We are, however, also making a technical amendment to the definition of erroneous payment in § 431.865(b). Specifically, we are changing the word ''in'' in paragraph (1) to ''if'' so that the definition reads: ''Erroneous payments means the Medicaid payment that was made for an individual or family under review who—(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received.'' The use of ''in'' instead of ''if'' clearly was a typographical error.

3. Rates of FFP for Program Services (§ 433.10)

We proposed to add a new paragraph (c)(4) to state that the FFP for services provided to uninsured children under an SCHIP Medicaid expansion program would be the enhanced FMAP established by SCHIP. We received no comments on this section and are implementing it as proposed.

4. Enhanced FMAP Rate for Children (§ 433.11)

Section 4911 the BBA, as amended by section 162 of Public Law 105–100, authorized an increase in the Federal medical assistance percentage (FMAP) used to determine the Federal share of State expenditures for services provided to certain children. Federal financial participation for these children will be paid at the enhanced FMAP rate determined in accordance with § 457.622, provided that certain conditions are met. The State's allotment under title XXI will be reduced by payments made at this enhanced FMAP, consistent with § 457.616.

Under proposed § 433.11(b) in order to be eligible to receive Federal payments at the enhanced FMAP, a State must:

(1) Not adopt income and resource standards and methodologies for determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under the State plan in effect on June 1, 1997;

(2) Have sufficient funds available under the State's title XXI allotment to cover the payments involved; and

(3) Maintain a valid method of identifying services eligible for the enhanced FMAP.

Under § 457.606, the State must also have an approved State plan in effect. For purposes of determining whether an income or resource standard or methodology is more restrictive than the standard or methodology under the State plan in effect on June 1, 1997, we proposed to compare it to the standard or methodology that was actually being applied under the plan on June 1, 1997. For purposes of this section, a pending Medicaid State plan amendment that would establish a more restrictive standard or methodology, but that has an effective date later than June 1, 1997, would not be considered ''in effect'' on June 1, 1997, regardless of when it was submitted. However, while States that adopt more restrictive income or resource standards or methodologies than those in effect on June 1, 1997 would not be eligible for enhanced FMAP, the proposed rule provided that if a State drops an optional eligibility group entirely, the prohibition against receiving enhanced FMAP does not apply.

In § 433.11, we proposed that the enhanced FMAP would be used to determine the Federal share of State expenditures for services provided to three categories of children. The first category for whom the enhanced FMAP would be available in the proposed rule was the new group of ''optional targeted low-income children'' described in proposed § 435.229. Under this category, the State would expand eligibility to a new group of children.

Under the second category the State would cover children who meet the definition of ''optional targeted low-income child'' by expanding coverage under existing Medicaid groups. Thus, a State would not need to adopt the new eligibility group of optional targeted low-income children in order to receive the enhanced match. As long as the newly-covered children under an expanded Medicaid group met the definition of targeted low-income child, including the requirements that they be uninsured and not eligible for Medicaid under the State plan in effect on March 31, 1997, the State could receive the enhanced match for them. (Note that the State could claim the regular FMAP for children covered by an expansion, who do not meet the definition of optional targeted low-income children because they are covered by private insurance.) These first two categories of children are reflected in proposed § 433.11(a)(1), which implements sections 1905(u)(2)(C) and 1902(a)(10)(A)(ii)(XIV) of the Act.

The third category for whom the State may receive the enhanced FMAP consists of children born before October 1, 1983 who would not be eligible for Medicaid under the policies in the Medicaid State plan in effect on March 31, 1997, but to whom the State subsequently extends eligibility by using an earlier birth date in defining eligibility for the group of poverty-level-related children described in section 1902(l)(1)(D) of the Act. The enhanced FMAP is available for services to children in this third category even if they have creditable health insurance, as defined at 45 CFR 146.113. We note that, as the statutory phase-in of poverty-level-related children under age 19 proceeds, the numbers of children in this third category will diminish; by October 1, 2002, all the children in this category will be included in the mandatory group of children described in section 1902(l)(1)(D) of the Act, and State spending for services to them will be matchable at the State's regular FMAP.

Concerning the second category above, it is unlikely that Congress intended to provide enhanced FMAP for services provided to children who, although not eligible under the policies in effect in the Medicaid State plan in effect on March 31, 1997, became eligible after that date due solely to a Federal statutory change or an already scheduled periodic cost-of-living increase. These types of changes are inherent in the State plan policies in effect on March 31, 1997. Enhanced FMAP will be available only when children are made eligible due to a change in State policy, which expands eligibility to cover previously ineligible children.

Federal payments made at the enhanced FMAP rate reduce the title XXI appropriation in accordance with section 2104(d) of the Act. Thus, HCFA must apply such payments against a State's title XXI allotment until that allotment is exhausted. After the title XXI allotment is exhausted, expenditures will be matched at the State's regular FMAP rate.

Comment: Three commenters objected to our proposal to allow a State to receive enhanced FMAP if the State drops an optional eligibility group that was covered on March 31, 1997 because the maintenance of effort provision in the statute was intended to prevent States from dropping Medicaid coverage in order to put children in a separate child health program. The commenters argued that our proposal is contrary to the statutory intent.

Response: We appreciate the commenters' concern. However, while the maintenance of effort provisions of the statute explicitly speak to more restrictive income and resource standards and methodologies, they do not reference other conditions of eligibility or other State actions, such as dropping optional eligibility groups.

Prior to the enactment of SCHIP, the overwhelming majority of children under 19 who were eligible for Medicaid under an optional category received coverage under the States' medically needy programs. By that time, children previously covered under other optional groups largely had been subsumed by the mandatory poverty-related eligibility groups. Given the further recent expansion of eligibility under the poverty-related groups and through the use of less restrictive income and resource standards and methodologies permitted under section 1931 of the Act, the number of children in these other groups has further diminished. Most of the children who remain covered under an optional group—other than those in a medically needy group—fall into the optional categorically needy group of children eligible under section 1902(a)(10)(A)(ii)(I) of the Act, often referred to as ''Ribicoff children.''

Under section 1902(a)(10)(C)(ii)(I) of the Act, States cannot drop only children under 19 from their medically needy programs. It is highly unlikely that a State would drop its entire

medically needy program in order to place a few children in SCHIP. Since the number of children in other optional eligibility groups is very small, there is little financial incentive for States to drop any of these groups either. The only reason a State might potentially drop one of its optional groups would be to cover the children under another, broader group. Such simplifications likely will promote enrollment of children and should not be discouraged.

In this context, two additional points are pertinent to understanding our decision. First, under the proposed regulation, States that eliminate an optional eligibility category will not be able to receive the enhanced FMAP for any children who would have been eligible for Medicaid under the eligibility standards for the dropped group in effect on March 31, 1997. Thus, the proposed regulations do not permit States to transfer any children from coverage under an optional Medicaid group to a stand-alone SCHIP program or to receive enhanced FMAP for such children under a Medicaid expansion. States simply would not be precluded from receiving the enhanced match for other children in its SCHIP program, which is what would happen if a State reduced coverage under a mandatory category.

Second, all Ribicoff children under age 19 will be subsumed by the mandatory poverty-level group by October 1, 2002, so any savings generated from eliminating this group, which, as discussed above would be nominal, would also be short-lived.

Accordingly, there is little incentive for States to eliminate any non-medically needy eligibility categories under Medicaid. In the highly unlikely event that a State nonetheless chose to do so, the number of children who would be affected would be minimal. The small number of potentially (but unlikely to be) affected children does not justify restricting States' ability to simplify their Medicaid programs in this regard.

Comment: One commenter requested that we add ''with or without creditable insurance'' to § 433.11(a)(2), to make it clear that the enhanced FMAP is available for children born before October 1, 1983 who would be described in section 1902(l)(1)(D) of the Act (the poverty-level children's group) if they had been born on or after that date and would not qualify for medical assistance under the State plan in effect on March 31, 1997, even if they have creditable health coverage.

Response: We have added ''with or without group health coverage or other health insurance coverage'' to § 433.11(a)(2) to clarify this point.

5. Optional Targeted Low-Income Children (§ 435.229)

Section 4911 of the BBA amended the Social Security Act by adding a new section 1902(a)(10)(A)(ii)(XIV) to establish an optional categorically-needy group of children referred to as ''optional targeted low-income children,'' and described in section 1905(u)(2)(C) of the Act. Section 1905(u)(2)(C), as added by section 4911 of the BBA, was subsequently revised by section 162 of Public Law 105–100 and, in the process, ''(C)'' was changed to ''(B)''. In an apparent oversight, no conforming change was made to section 1902(a)(10)(A)(ii)(XIV) of the Act to refer to section 1905(u)(2)(B), rather than to 1905(u)(2)(C). Since it appears that this was simply a drafting error, we consider the reference to 1905(u)(2)(C) in this section to be a reference to 1905(u)(2)(B).

Section 1905(u)(2)(B) defines an optional targeted low-income child as a child who meets the definition of a targeted low-income child in section 2110(b)(1) of title XXI of the Act and who would not qualify for Medicaid under the Medicaid State plan in effect on March 31, 1997. Because only a child under 19 can qualify as a targeted low-income child under section 2110(b)(1) of the Act (see section 2110(c) of the Act), to be covered as an optional targeted low-income child under Medicaid, an individual also must be under 19 (even though individuals between 19 and 21 can qualify for Medicaid under other eligibility groups).

The very specific cross reference in section 1905(u)(2)(B), to section 2110(b)(1), for the definition of an optional targeted low-income child indicates that the Medicaid definition of ''optional targeted low-income child'' is based only on section 2110(b)(1). Thus, the definition of ''targeted low-income child'' for Medicaid does not include the exclusions described in section 2110(b)(2) that apply to the definition of ''optional targeted low-income child'' for separate child health programs under title XXI. Specifically, the following groups of children are excluded from eligibility for a separate child health program under title XXI, but are not excluded from eligibility for Medicaid: (1) children who are inmates of public institutions and patients in institutions for mental diseases (IMD); and (2) children who are eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

Under existing Medicaid eligibility rules, there is no eligibility exclusion for children who are inmates of a public institution, patients in an IMD, or children eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State, although restrictions on Federal financial participation (FFP) apply under some circumstances. Specifically, no FFP is available under Medicaid for services provided to inmates of public institutions or patients in an IMD. We note that under Medicaid, if, under section 1905(a)(16) of the Act, a State elects to cover inpatient psychiatric services for individuals under age 21, FFP is available for services furnished to children in psychiatric facilities for individuals under age 21 that meet certain standards and conditions (see § 441.150ff).

Turning to the proposed rule, the definition of optional targeted low-income child at section 1905(u)(2)(B) of the Act excludes children who would have been eligible for medical assistance under the State plan in effect on March 31, 1997 on any basis, thus including those who would have been eligible under a State's medically needy group. This exclusion was set forth in proposed § 435.229(a)(2). We explained in the preamble to the proposed rule that we would interpret section 1905(u)(2)(B) to exclude children who would have been eligible as medically needy based on their current financial status without a ''spend-down,'' an amount that can be spent on medical care before the child can become eligible. However, children who would have been eligible for Medicaid under the State plan in effect on March 31, 1997 only after paying a spend down would not be excluded, because they would not have been eligible for Medicaid until the spend-down had been met.

We explained in the preamble for proposed § 435.229 that the regular Medicaid financial methodologies that govern eligibility of children in a State, that is, the income and resource methodologies under the State's AFDC plan in effect on July 16, 1996, must also be used to determine whether a child is eligible under the new group of optional targeted low-income children. However, a State may use the authority of section 1902(r)(2) of the Act to adopt less restrictive methods of determining countable income and resources for this group.

States that choose to cover a group of optional targeted low-income children also must apply uniform income and

resource eligibility standards for the group throughout the State. States also are required to provide all services covered under the plan, including EPSDT services, to optional targeted low-income children. Indeed, as we explained in the preamble to the proposed rule, States must apply all regular Medicaid rules. We thought it worth emphasizing that this includes Medicaid rules pertaining to immigration status.

States are not required to provide coverage to all children who meet the definition of an optional targeted low-income child. As with the existing Medicaid rules, eligibility under the optional group can be limited to a reasonable group or reasonable groups of such children. However, this option, reflected in proposed § 435.229(b)(2), does not allow States to limit a group by geographic location because of the requirement in section 1902(a)(1) of the Act that a State plan be in effect in all political subdivisions of the State. Also, as explained in the preamble to the proposed rule, we do not consider it reasonable to limit a group by age other than by those age groups specified by Congress in section 1905(a)(1) and referenced in section 1902(a)(10)(A)(ii). We believe that if Congress had intended to allow other uses of age to establish categories of eligibility, the statute would not have specified any age groups. We note that, in the case of the group of optional targeted low-income children, a State does not have the option to cover a reasonable category of children under age 21 or 20, because for purposes of defining ''targeted low-income child'' for title XXI programs and ''optional targeted low-income child'' for Medicaid expansion programs, ''child'' is defined in section 2110(c)(1) of the Act as a child under age 19. (This age limitation applies to all optional targeted low-income children, not only those in the optional group.)

Section 2110(b)(1)(B) refers to the Medicaid applicable income level, which, under 2110(b)(4), explicitly recognizes potentially different levels based upon the age of a child. The income standard for the optional categorically-needy group of optional targeted low-income children may be different for infants, children under age 6, and children between ages 6 and 18 (that is, under age 19) if the State's Medicaid applicable income levels for these age groups differ.

We did not propose to require or allow States to apply eligibility-related private health insurance substitution provisions, such as periods of uninsurance, to the ''optional targeted low-income children'' group because such eligibility conditions are inconsistent with the entitlement nature of Medicaid and are therefore not permitted by the Medicaid statute in the absence of a section 1115 waiver.

Finally, we explained in the preamble to the proposed rule that States are obligated to continue to provide services to eligible optional targeted low-income children after its title XXI allotment is exhausted, unless the Medicaid State plan is amended to drop the group of optional targeted low-income children. Once the title XXI allotment is exhausted, Medicaid matching funds are available for these children at the regular matching rate rather than the enhanced rate.

Comment: Two commenters requested that the Medicaid regulations include a definition of optional targeted low-income child because they found the cross-reference to the title XXI regulations is confusing. They also noted that some provisions in title XXI, such as permitting States to limit eligibility by geographic region, do not apply in Medicaid.

Response: We accept the commenters' request to clarify the definition of optional targeted low-income child in the Medicaid regulations, rather than cross-reference § 457.310(a). In proposed § 435.229(a), the cross-reference to § 457.310(a) resulted in the inclusion of some provisions of the definition of targeted low-income child that only apply to separate child health programs. Therefore, we have removed the cross-reference in § 435.229 to § 457.310(a) and added a Medicaid-specific definition of optional targeted low-income child to § 435.4 (for the States, the District of Columbia, the Northern Mariana Islands, and American Samoa) and to § 436.3 (for Guam, Puerto Rico, and the Virgin Islands). The definition of optional targeted low-income child applies to the optional categorically needy group of optional targeted low-income children under § 435.229 and § 436.229 for whom the enhanced FMAP is available.

Specifically, §§ 435.4 and 436.3 include the following children in the definition of ''optional targeted low-income child'': (1) children who have family income at or below 200 percent of the Federal poverty line for a family of the size involved; (2) children who reside in a State which does not have a Medicaid applicable income level, as that term is defined in § 457.10; or (3) children who reside in a State that has a Medicaid applicable income level and has a family income that exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or (4) children whose income does not exceed the effective income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997. As noted, we have revised the definition to clarify that an optional targeted low-income child that resides in a State that has a Medicaid applicable income level may have family income that exceeds the Medicaid applicable income level, but does not exceed the effective income level that has been specified under the policies of the State plan under title XIX on June 1, 1997. This provision effectively allows children who became eligible for Medicaid as a result of an expansion after March 31, 1997 but before June 1, 1997 may be considered optional targeted low-income children. It also means that children who were below the Medicaid applicable income level, but were not Medicaid eligible due to financial reasons that were not related to income (for example, due to an assets test) can be covered by SCHIP.

Furthermore, the definition in § 435.4 and § 436.3 requires that an optional targeted low-income child must not be: (1) Eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; or (2) covered under a group health plan or under health insurance coverage unless the health insurance coverage program is offered by the State, has been in operation since before July 1, 1997, and the State receives no Federal funds for the program's operation. A child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan. These criteria mirror the provisions of proposed § 457.310, except those that apply only to separate title XXI child health programs.

Comment: Three commenters indicated that children who were covered by section 1115 demonstration projects with a limited benefit package should not be considered to have been recipients of Medicaid, and therefore should not be excluded from the definition of optional targeted low-income children. They urged HCFA to provide a regulatory clarification so that children eligible under a section 1115 demonstration project that only provided a limited range of services would be eligible for enhanced matching under the definition of an ''optional targeted low-income child.''

Response: We agree with the commenters and have therefore revised the definition of the term ''Medicaid applicable income level'' at § 457.10, to address their concerns. Specifically, in § 457.10 we clarify that, for purposes of the definition of ''Medicaid applicable

income level,'' the term ''policies of the State plan'' includes policies under most section 1115(a) Statewide demonstration projects; however, the term does not include section 1115(a) demonstrations that granted coverage to a new group of eligibles but which did not provide inpatient hospital coverage, or which limited eligibility both by allowing only children who were previously enrolled in Medicaid to qualify and imposing premiums as a condition of participation in the demonstration. This exception does not apply to waivers that extended the time period or conditions under which an individual could receive transitional medical assistance.

The exclusion of children eligible for medical assistance under the State plan in effect as of March 31, 1997 was intended to ensure that States did not transfer coverage of low-income children who would have been eligible under their Medicaid program at the regular Federal matching rate to the enhanced matching rate established by SCHIP. However, this provision does not specifically address the treatment of children who could have been covered under a section 1115 demonstration project in effect on March 31, 1997.

Our understanding is that the provision was not intended to preclude States from claiming enhanced matching funds for expanded coverage to children whose income is below the demonstration project eligibility thresholds in place as of March 31, 1997, if those programs did not offer comprehensive coverage or limited eligibility to individuals who were previously enrolled in Medicaid and imposed premiums as a condition of participation. Demonstrations that had these types of restrictions are significantly more limited in scope (either in coverage or eligibility) than ''traditional'' Medicaid programs. Our experience with SCHIP and our increased understanding of how this provision is affecting States' ability to expand coverage have led us to agree with the commenters that an overly broad interpretation of the exclusion contained in section 1905(u)(2)(B) of the Act would be contrary to the intent of the statute. Furthermore, because enrollment in these types of demonstrations is relatively small, any supplantation of State dollars would be minimal. Therefore, we have clarified this provision in the final rule.

Comment: Several commenters supported the proposal that EPSDT policies apply to optional targeted low-income children. One of these commenters also agreed that there should not be a required period of uninsurance for these children and encouraged HCFA to explicitly prohibit such a requirement.

Response: EPSDT applies to this group of children because they are in a Medicaid group and entitled to all benefits and protections provided to children under Medicaid law and regulations. With respect to periods of uninsurance, we have not included the prohibition against requiring a period of uninsurance in the regulation text for this provision since periods of uninsurance are already prohibited by the Medicaid statute and regulations. We believe that this prohibition is inherent in the entitlement nature of Medicaid. States may not impose conditions of eligibility other than those specifically allowed by statute, regulation, or waiver. We will work with States that have such policies in place to assure that the requirements of the statute are met.

6. Furnishing a Social Security Number (§ 435.910)

Section 1137(a)(1) of the Act requires applicants and recipients of Medicaid to furnish the State with their social security number(s) as a condition of eligibility. While the United States Supreme Court in *Bowen v. Roy*, 476 U.S. 693 (1986) upheld this requirement, it did so in a plurality decision in which some of the Justices held that the challenge was moot because the claimant had obtained a social security number. As a result, that decision did not foreclose someone else with religious objections to applying for a social security number from challenging the constitutionality of section 1137(a)(1) of the Act. The Religious Freedom Restoration Act of 1993 also raised questions about the requirements of section 1137(a)(1) of the Act in cases involving religious objections.

Consequently, in 1995 HCFA announced a policy that permits States to obtain or assign alternative identifiers to eligible individuals who object to obtaining an SSN on religious grounds. This policy was adopted in order to enable States to administer Medicaid in the most efficient manner possible. In § 435.910 of the proposed rule we attempted to accommodate the purpose of section 1137(a)(1) with the Constitution's protection of freedom of religion and the dictates of the 1993 Act by permitting alternative identifiers.

We received no comments on this section. However, we wish to clarify that the statute requires an SSN of applicants and recipients only. States may request but may not require other individuals in the household to provide their SSN's. For example, if application is made on behalf of a child and the parent is not applying, the State may request the parent's SSN but must note that the SSN is not required and may not deny the child's eligibility if the parent does not provide his/her own SSN.

7. FFP for Services and FFP for Administration (§ 435.1001 and § 435.1002)

Section 1920A of the Act allows States to provide services to children under age 19 during a period of presumptive eligibility. The implementation of this provision is discussed below. In accordance with this new option, we proposed to amend § 435.1001 to provide FFP for necessary administrative costs incurred by States in determining presumptive eligibility for children and providing services to presumptively eligible children. In § 435.1002 we proposed to provide FFP for services covered under a State's plan which are furnished to children during a period of presumptive eligibility. We received no comments on either of these sections and are implementing them as proposed.

8. Exemption From the Limitation on FFP for Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries (§ 435.1007)

Section 162 of Public Law 105–100 amended 1903(f)(4) of the Act to add the optional group of optional targeted low-income children and other children for whom enhanced FMAP is available to the list of those who are exempt from the limitations on FFP found in section 1903(f). All previous citations in section 1903(f) were references to Medicaid eligibility groups, whereas this new provision adds not an eligibility group per se, but rather children on whose behalf enhanced FMAP is available.

With certain exceptions, section 1903(f) limits FFP to families whose income does not exceed 133⅓ percent of the amount that ordinarily would have been paid to a family of the same size without any income or resources, in the form of money payments under the Aid to Families with Dependent Children program. This provision effectively limits the use of the authority under section 1902(r)(2) to expand eligibility through the use of less restrictive income and resource methodologies for those groups that are not exempt from the limitation.

However, section 162 of Public Law 105–100 could result in extending the exemption from the FFP limitation to children other than (1) children in the optional eligibility group of optional

targeted low-income children or (2) children in other groups already exempt from the FFP limitation. If this were to occur, a conflict with the comparability requirements of section 1902(a)(17) and § 435.601(d)(4) of the Medicaid regulations could arise. If, for example, a State sought to use more liberal income methodologies for counting income in determining the medically-needy eligibility of optional targeted low-income children than used for counting income in determining the medically-needy eligibility of other children, the comparability requirements would be violated.

Because the exemption from the FFP limit did not override the comparability requirement of the Medicaid statute, we proposed to continue to apply the FFP limitations described in § 435.1007 to all children who are covered as medically-needy and to any optional categorically-needy group which is subject to the FFP limit. States may use more liberal methodologies under section 1902(r)(2) of the Act for the optional categorically-needy group composed exclusively of optional targeted low-income children without reference to the FFP limitations of section 1903(f). We received no comments on this section and have adopted this portion of the rule as proposed.

9. Presumptive Eligibility for Children (Part 435, Subpart L)

Section 4912 of the BBA added a new section 1920A to the Act to allow States to provide services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility. We set forth the basis and scope of subpart L in proposed § 435.1100.

Under section 1920A of the Act, only a ''qualified entity'' can determine whether a child is presumptively eligible for Medicaid on the basis of preliminary information about the child's family income. In accordance with section 1920A(b)(3)(A) of the Act, we define a qualified entity in § 457.1101 as an entity that is determined by the agency to be capable of making determinations of presumptive eligibility for children and that— (1) furnishes health care items and services covered under the approved Medicaid State plan and is eligible to receive payments under the approved plan; (2) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act; (3) is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990; or (4) is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966. In addition, the Benefits Improvement and Protection Act of 2000 (BIPA) (P.L. expanded this list of qualified entities to include an entity that (5) is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801); (6) is an elementary or secondary school operated or supported by the Bureau of Indian Affairs; (7) is a State or Tribal child support enforcement agency; (8) is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act; (9) is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or (10) is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437 *et seq.*) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or (11) any other entity the State so deems, as approved by the Secretary.

Finally, section 1920A(b)(3)(B) also authorizes the Secretary to issue regulations further limiting those entities that may become qualified entities. We note that, although State agency staff can receive and process applications for regular Medicaid, they cannot make presumptive eligibility determinations unless they themselves meet the definition of a ''qualified entity'' under § 457.1101.

We note that the date that the completed regular Medicaid application form is received by the Medicaid State agency is the Medicaid filing date for Medicaid eligibility, unless State agency staff are located on site at the qualified entity, in which case the Medicaid filing date is the date that the onsite State agency staff person receives the completed form. Alternatively, the State can opt to consider the date the determination of presumptive eligibility is made as the Medicaid application date.

In accordance with section 1920A(b)(2), we also proposed in § 435.1101 that the period of presumptive eligibility begins on the day that a qualified entity makes a determination that a child is presumptively eligible. The child would then have until the last calendar day of the following month to file a regular Medicaid application with the Medicaid agency. If the child does not file a regular Medicaid application on time, presumptive eligibility ends on that last day. If the child files an application for regular Medicaid, presumptive eligibility ends on the date that a determination is made on the regular Medicaid application.

Finally, proposed § 435.1101 defined ''applicable income level'' as the highest eligibility income standard established under the State plan which is most likely to be used in determining the Medicaid eligibility of the child for the age involved. We note that there may be different applicable income levels for children in different age groups. For example, the standards for presumptive eligibility might be 133 percent of the Federal poverty level (FPL) for children under 6 and 100 percent FPL for children age 6 through 19, if these were the highest standards applicable to children of the specified ages under a State's Medicaid plan.

We proposed in § 435.1102(a) to provide limited flexibility to States in calculating income for purposes of determining presumptive eligibility. We also explained in the preamble to the proposed rule that under § 435.1102(a) we would allow States to require that qualified entities request and use general information other than information about income, as long as the information can be obtained through the applicant's statements and is requested in a fair and nondiscriminatory manner. With respect to income, in States that adopt the most conservative approach to presumptive eligibility, the qualified entity would use gross family income. The qualified entity would compare gross family income to the applicable income level, as defined in § 435.1101.

For States wishing to adopt a more liberal approach, however, we specifically proposed to allow States to require that qualified entities apply simple income disregards, such as the general $90 earned income disregard. However, as explained in the preamble we did not propose to allow States to require that qualified entities deduct the costs of incurred medical expenses in order to reduce income to the allowed income level. We solicited comments on whether States should be allowed to require that qualified entities make certain adjustments to gross income and ways that these adjustments could be limited.

Proposed §§ 435.1102(b)(1) and (b)(2) implement the provisions of section

1920A(b)(1) of the Act. Section 435.1102(b)(1) requires that States provide qualified entities with regular Medicaid application forms (defined in proposed § 435.1101) as well as information on how to assist parents, guardians, and other persons in completing and filing such forms. At a minimum, we proposed that States must furnish qualified entities with the applications used to apply for Medicaid under the poverty-related groups described in section 1902(l)(1) of the Act.

Proposed § 435.1102(b)(2) requires States to establish procedures to ensure qualified entities—(1) notify the Medicaid agency that a child is presumptively eligible within 5 working days; and (2) provide written information to parents and custodians of children determined to be presumptively eligible, explaining that a regular Medicaid application must be filed by the last day of the following month in order for the child to continue to receive services after that date and that if an application is timely filed on the child's behalf, the child will remain presumptively eligible until a determination of the child's eligibility for regular Medicaid has been made; and (3) provide written information to parents and custodians of children determined not to be presumptively eligible of the reason for the determination and that the child has a right to apply to regular Medicaid.

While we are requiring such notification, we are considering presumptive eligibility to be a special status, distinct from regular Medicaid eligibility. Therefore, we did not propose to apply to a decision on presumptive eligibility the notification requirements, found in §§ 435.911 and § 435.912 and part 431, subpart E, that a State must meet when it makes a decision on a regular Medicaid application. Nor did we propose to grant rights to appeal a denial or termination of services under a presumptive eligibility decision because a determination of presumptive eligibility is not considered to be a determination of Medicaid eligibility. If a regular Medicaid application is filed on the child's behalf and is denied, the child would have the right to appeal that denial.

Because presumptive eligibility is a special status, we considered whether States should be required to provide all services to presumptively eligible children or whether they should be permitted to limit the services provided. In § 457.1102(b)(3), we proposed to require that States provide all services covered under the State plan, including EPSDT, to presumptively eligible children.

Although section 1920A places no restrictions on the number of periods of presumptive eligibility for a child, it undermines the intent of the provision to provide a child with an unrestricted number of periods. Therefore, we proposed in § 435.1102(c) to allow States to establish reasonable methods of limiting the number of periods of presumptive eligibility that can be authorized for a child in a given time frame. We solicited comments on what would constitute a reasonable limitations and whether specific limitations on the number of periods of presumptive eligibility should be imposed by regulation.

Existing regulations at § 435.914 permit States to provide Medicaid for an entire month when the individual is eligible for Medicaid under the plan at any time during the month. However, as explained in the preamble to the NPRM, because a determination of presumptive eligibility is not, by definition, a determination of Medicaid eligibility, but simply a decision of temporary eligibility based on a special status, and because section 1920A(b)(2) of the Act expressly defines the period of presumptive eligibility, we did not propose to permit States to provide full-month periods of presumptive eligibility.

Section 4912 of the BBA provides that, for purposes of Federal financial participation, services that are covered under the plan, furnished by a provider that is eligible for payment under the plan, and furnished to a child during a period of presumptive eligibility, will be treated as expenditures for medical assistance under the State plan. This provision is reflected in proposed § 435.1001. We note that in the event that a child determined to be presumptively eligible is not found eligible for Medicaid after a final eligibility determination, the services provided during the presumptive eligibility period that otherwise meet the requirements for payment will be covered. See § 447.88 and § 457.616 for a discussion of the options for claiming FFP payment related to presumptive eligibility.

Comment: We received one comment that the regulations should clarify that a State can provide a joint SCHIP/Medicaid application or a shortened Medicaid application used for pregnant women and children as well as a ''regular Medicaid application.''

Response: We agree that a qualified entity may provide parents and caretakers with either a shortened application that is used to establish eligibility for pregnant women and children under the poverty-level-related groups described in section 1902(l) of the Act or a joint application for a separate child health program and Medicaid that is used to establish eligibility of children. We have revised the definition of ''application form'' in § 435.1101 to include the joint SCHIP/Medicaid application for a Medicaid and a separate child health program.

We would like to clarify that, under Federal law, no application form for presumptive eligibility itself is required. Thus, qualified entities can make presumptive-eligibility determinations based strictly on oral information. (The qualified entity would need to record the pertinent information, but the parent or caretaker (or other responsible adult) would not themselves need to complete an application.) This would not preclude qualified entities from assisting families in completing and filing the regular Medicaid application to the extent permitted under law, and we strongly encourage them to do so.

Alternatively, a State may choose to use a written application for presumptive eligibility, although it cannot require the parent or caretaker to provide information other than the information on income necessary to make the determination.

We encourage States that choose to use a written application, particularly those with simplified Medicaid application forms, to use the same form for presumptive eligibility as that used for regular Medicaid, as this will eliminate the need for the child's family to complete two forms. The parent or caretaker can be encouraged to complete the application and assisted in doing so. But, again, so long as pertinent information on income is provided, presumptive eligibility in a State that has elected this option cannot be denied because the full application is not completed.

In either event, of course, the State must provide qualified entities with information on how to assist families in completing and filing the application and ensure that they give presumptive-eligibility applicants a Medicaid application form. We also strongly encourage States, in turn, to encourage qualified entities to provide such assistance to the extent permitted under Medicaid law and regulations.

Comment: One commenter specifically supported the requirement that presumptive eligibility must be provided Statewide and one commenter specifically objected to this requirement. A third commenter objected to requiring each qualified entity to conduct Statewide

presumptive eligibility outreach and determination.

Response: We have considered the commenters' suggestions and have retained proposed § 435.1102(b)(4) related to Statewide availability of presumptive eligibility. Section 1920A(b)(3)(C) provides States with the authority to limit the classes of entities that may become qualified entities; and therefore may limit the population that have the opportunity to become presumptively eligible. For example, States could designate WIC agencies to make determinations of presumptive eligibility only for the clients who have applied for or are receiving WIC, but all of the WIC agencies across the State would be required to offer presumptive eligibility. Therefore, a State could effectively limit the availability of presumptive eligibility by designating particular qualified entity to offer it.

Comment: One commenter noted that schools would not be able to do determinations of presumptive eligibility for pre-schooled, home-schooled, drop-outs or graduates.

Response: Although schools are not likely to be in regular contact with children falling into one of these groups, and as a practical matter may not be in a position to make presumptive eligibility decisions for them, schools that are Medicaid providers would not be precluded from determining the eligibility of a child simply because the child did not attend the school. Thus, schools would also be authorized to determine the presumptive eligibility of the children identified by the commenter.

Comment: We received one comment concerning verification of information used to determine presumptive eligibility. The recommendation was that the regulations specifically require that ''self-attestation'' be used for determinations of presumptive eligibility if income disregards are used and that in other cases, HCFA encourage States to allow applicants to attest to information required for a determination of presumptive eligibility without providing documentation.

Response: We have revised § 435.1102 to make it clear that an estimate of income is to be used for purposes of presumptive eligibility determinations even when a State has chosen to apply simple disregards. The statute provides that determinations of presumptive eligibility are based on ''preliminary information'' and we do not believe that requiring documentation is consistent with the intent that the process be simple for both the applicant and the provider and result in immediate eligibility. Therefore, an applicant's self-attestation as to income is all that would be required to establish the amount of income for presumptive eligibility determinations, regardless of whether income disregards are used or not. This is consistent with the proposed rules pertaining to presumptive eligibility for pregnant women, published March 23, 1994 (59 FR 13666).

Comment: One commenter specifically supported allowing only simple disregards in determinations of presumptive eligibility. Another commented that States should be free to decide whether to use gross or net income for determinations of presumptive eligibility.

Response: We appreciate the support and agree in part with the second commenter. States are free to use only gross income. States may also apply simple disregards to gross income such as a general earned income disregard. However, it would not be consistent with statutory intent to allow States to require that qualified entities apply complicated income disregards or make complicated determinations. Therefore, we have not revised proposed § 457.1102(a) in this final regulation.

Comment: Three commenters expressed support for requiring that, in proposed § 457.1102(b)(3), presumptive eligibility include EPSDT services. One of these commenters urged that the preamble discuss the steps that States should take to assure that EPSDT services are provided.

Response: We are not including any specific EPSDT guidance in this regulation. The regular Medicaid policies which pertain to EPSDT, including policies about providing information about EPSDT services to families and generally informing families about the benefits of preventive health, would apply when a child is found presumptively eligible for Medicaid.

Comment: We received several comments concerning written notices provided to the family and the responsibilities of qualified entities. One comment was that it would be difficult for schools to issue the notice of presumptive eligibility and the temporary enrollment card and the State should be allowed to do this instead. Another was that it would be difficult for schools to send a written notice to those found not to be presumptively eligible and might result in the family's confusion and anger. One comment was that, generally, HCFA should encourage States to develop procedures that are not burdensome to providers, provide adequate training and provider relations, and keep the provider apprized of the status of the application so that, if not completed at the time of any follow-up visit, the provider can encourage the family to complete the process, as necessary.

Response: Our understanding is that the intent of the legislation is to minimize the burden placed on qualified entities, including schools and other providers. However, the statute specifically requires that the qualified entity inform the family that an application for Medicaid must be filed by the end of the following month. It is also clear that qualified entities are expected to provide Medicaid applications and assistance in completing and filing such applications. We certainly encourage States to simplify the presumptive eligibility process to the greatest extent allowed under the law. It is not unnecessarily burdensome for the qualified entity to provide written notices to those found presumptively eligible or ineligible, as these notices could be pre-printed notices provided by the State.

Although we have not required it, it would not be unnecessarily burdensome for a State to require a qualified entity to provide a temporary enrollment card to enable the child to access services during the period of presumptive eligibility particularly when the qualified entity itself does not provide medical services. We also encourage States to keep qualified entities apprized of the status of the child's application if the entity is willing to follow up with families whose application has not been completed.

Comment: One commenter suggested that § 435.1102(b)(2)(iii) should be amended to require that qualified entities tell individuals who are not found presumptively eligible for Medicaid that they may file for coverage under a separate child health program as well as Medicaid and provide applications for both programs as well as information on how to complete and file them.

Response: We have not required that qualified entities provide information about a separate child health program. However, we encourage States to do this as part of their outreach programs and coordination efforts. In addition, as noted above, we have amended § 435.1101 to make it clear that the application provided by a qualified entity may be a joint Medicaid/SCHIP application.

Comment: One commenter urged HCFA to encourage States to simplify the enrollment process and provide prompt, easy-to-understand information to the family about the eligibility determination process and any remaining steps that the family must

take. Another expressed concern that States are not required to send a notice at the end of a presumptive-eligibility period, which would alert families who sent in a Medicaid application that was never received.

Response: HCFA has encouraged States to simplify both the eligibility requirements and the enrollment procedures to the greatest extent possible and will continue to do so. We also encourage States to make all information provided to families understandable and will provide technical assistance in this area. We encourage States to notify families that the child's presumptive eligibility will be terminated and that no Medicaid application has been received. We also encourage States to establish other procedures to follow-up with families of presumptively-eligible children early on in the presumptive-eligibility period. However, requiring States to do so is beyond the intent of the statute, and could discourage some States from adopting presumptive eligibility for children at all. We will not mandate that States institute such procedures.

Comment: We received several comments in response to our specific request related to limitations on the number of periods of presumptive eligibility available to a child. One commenter believed that no more than one period of presumptive eligibility within 24 months would be reasonable, but recommended that States be allowed to set their own standards. Another commenter agreed it would be unreasonable to provide unlimited periods of presumptive eligibility, but believed that it would be reasonable to allow only one period per lifetime. A third recommended that there be no lifetime limit on the number of periods, but a limit on the number of periods within a specific time-frame (for example, one period of presumptive eligibility within a twelve-month period). A final commenter believed that it would be difficult for providers, who are considered qualified entities, to track the number of presumptive-eligibility any child has enjoyed.

Response: We have decided to require that States adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child within a given period of time. Under some circumstances, more frequent or numerous periods of presumptive eligibility may be justified and individual circumstances may be taken into account. We are not requiring that States establish a specific maximum number of periods for specific time frames in this final regulation. We realize that the circumstances that result in a need for an additional period of presumptive eligibility will vary greatly from case to case. In addition, States may wish to have some experience before setting up a standard that qualified entities must follow. We expect States to monitor the use of presumptive eligibility to determine whether there is a need for specific limitations on the number of periods of presumptive eligibility to which a child is entitled.

We appreciate the support for our position that it would be unreasonable to provide unlimited periods of presumptive eligibility. However, if a State decides to establish set limits, we do not agree that one period of presumptive eligibility in a lifetime is reasonable given the changes in a child's circumstances that may occur over time. It would be reasonable, however, to limit the periods of presumptive eligibility to one per twelve or twenty-four month period, as suggested. Furthermore, it would be reasonable to connect limitations on presumptive eligibility to the length of time during which a child is not covered by Medicaid. For example, a State could prohibit an additional period of presumptive eligibility until the child had been disenrolled from Medicaid for a certain period of time. In response to the last commenter, after a State has established how it will restrict the number of periods of presumptive eligibility, we expect that the State will develop procedures for assuring that the restrictions are applied without unduly burdening the qualified entities, including providers.

L. Medicaid Disproportionate Share Hospital (DSH) Expenditures

Section 4911 of the BBA amended section 1905(b) of the Act to require that for expenditures under section 1905(u)(2)(A)(that is, medical assistance for optional targeted low-income children) or section 1905(u)(3) (that is, medical assistance for children referred to as ''Waxman children''), the Federal medical assistance percentage is equal to the *enhanced* FMAP described in section 2105(b)of the Act unless the State has exhausted its title XXI allotment, in which case the State's regular FMAP would apply. In other words, under the statute, States that provide health insurance coverage to children as an expansion of their Medicaid programs may receive an enhanced match for services provided to the Medicaid expansion population.

Under the authority of section 1902(a)(13)(A)(iv) of the Act, States are required to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs when developing rates for Medicaid inpatient hospital services. Medicaid disproportionate share hospital (DSH) expenditures thus are payments made for hospital services rendered to Medicaid-eligible patients. Depending on the State's DSH methodology, some of the payments may be directly identifiable as expenditures for services for a child in a SCHIP-related Medicaid expansion program. HCFA concluded in the proposed rule that those identifiable payments must qualify for the enhanced FMAP.

We further proposed § 433.11 which set forth provisions regarding the enhanced FMAP rate available for State DSH expenditures related to services provided to children under an expansion to the State's current Medicaid program. However, based on the statutory changes included in the ''Medicare, Medicaid, and CHIP Balanced Budget Refinement Act of 1999,'' this section is being deleted. Specifically, H.R. 3426 incorporated changes to section 1905(b) (42 U.S.C. 1396d(b)) by inserting the phrase ''other than expenditures under section 1923,'' after ''with respect to expenditures.'' By inserting this phrase, the statute specifically excludes Medicaid DSH expenditures from qualifying for enhanced FMAP.

III. Provisions of the Final Rule

In this final rule, we are adopting the provisions as set forth in the November 8, 1999 proposed rule with the following substantive revisions:

A. Part 431—State Organization and General Administration

We added a new § 431.636 to provide for coordination of Medicaid with the State Children's Health Insurance Program. This section provides that the State must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment process has been initiated.

B. Part 433—State Fiscal Administration

We removed proposed paragaph § 433.11(b)(3) regarding enhanced FMAP for disporportionate share hospital expenditures provided to certain children.

C. Part 435—Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa

- We added a definition of optional targeted low-income child at § 435.4.

• We revised § 435.229 to refer to optional targeted low-income children as defined at § 435.4.

• We revised § 435.910(h)(3) to provide that a State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

• At § 435.1101 we replaced the term ''applicable income level'' with the term ''presumptive income level.'' The definition for this term remains the same.

• We revised the requirement at proposed paragraph § 435.1102(b)(4) to provide that agencies that elect to provide services to children during a period of presumptive eligibility must allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

D. Part 436—Eligibility in Guam, Puerto Rico, and the Virgin Islands

In the proposed rule, we inadvertently omitted certain revisions to part 436. The following revisions parallel the changes made to part 435:

• We added a definition of optional targeted low-income children at § 436.3.

• We added a new § 436.229, regarding provision of Medicaid to optional targeted low-income children.

• We revised paragraph (a) of § 436.1001, regarding FFP for administration.

• We added a new paragraph (c) to § 436.1002, regarding FFP for services.

• We added a new subpart L, Option for Coverage of Special Groups.

E. Part 457—Allotments and Grants to States

• We replaced the term ''Children's Health Insurance Program'' with the term ''State Children's Health Insurance Program'' throughout the regulation.

• We replaced the term ''beneficiary'' with the term ''applicant'' or ''enrollee'' throughout the regulation.

Subpart A—Introduction; State Plans for State Child Health Insurance Programs and Outreach Strategies

Section 457.10

• We added definitions for the following terms: ''applicant'', ''cost sharing'', ''enrollee'', ''enrollment cap'', ''health care services'', ''health insurance coverage'', ''health insurance issuer'', ''health services initiatives'', ''joint application'', ''optional targeted low-income child'', and ''premium assistance program''.

• For the following terms, we eliminated the cross reference and set forth the full text of the definition at § 457.10: ''contractor'', ''emergency medical condition'', ''emergency services'', ''health benefits coverage'', ''managed care entity'', ''post-stabilization services''.

• We revised the definition of American Indian/Alaska Native (AI/AN) by removing the provision that descendants in the first or second degree of members of Federally recognized tribes are considered AI/AN.

• We removed the definitions of ''contractor'', ''cost-effectiveness'', ''employment with a public agency'', ''grievance'', ''legal obligation'', ''post-stabilization services'', ''premium assistance for employer sponsored group health plans'', and ''State program integrity unit''.

Section 457.40

• We revised paragraph (c) to require that the State must identify, in the State plan or State plan amendment, by position or title, the State officials who are responsible for program administration and financial oversight.

Section 457.60

• We revised proposed paragraph (a)(1) (now paragraph (a)) to provide that a State must amend its State plan whenever necessary to reflect changes in Federal law, regulations, policy interpretations, or court decisions that affect provisions in the approved State plan.

• We revised proposed paragraph (a)(2) (now paragraph (b)) to provide that a State must amend its State plan whenever necessary to reflect changes in State law, organization, policy, or operation of the program that affect the following program elements: Eligibility, including enrollment caps and disenrollment policies; procedures to prevent substitution of private coverage, including exemptions or exceptions to periods of uninsurance; the type of health benefits coverage offered; addition or deletion of specific categories of benefits offered under the plan; basic delivery system approach; cost-sharing; screen and enroll procedures, and other Medicaid coordination procedures, review procedures, and other comparable required program elements.

• We revised proposed paragraph (a)(3) (now paragraph (c)) to provide that a State must amend its State plan to reflect changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

Section 457.65

• We added a new paragraph (d) to set forth requirements for amendments relating to enrollment procedures.

• We redesignated proposed paragraphs (d) and (e) as paragraphs (e) and (f), respectively.

• We removed proposed paragraph (d)(2), as this provision has been incorporated into § 457.60(c).

• We added a new paragraph (f)(2) to provide that an approved State plan continues in effect unless a State withdraws its plan in accordance with § 457.170(b).

Section 457.70

• We removed proposed paragraph (c)(1)(vi), which provided that Medicaid expansion programs must meet the requirements of subpart H of this final rule.

Section 457.80

• We revised paragraph (c) to provide that the State plan must include a description of procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children.

Section 457.90

• We added a new paragraph (b)(3) to provide that outreach strategies may include application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

Section 457.110

• We revised paragraph (a) to provide that the State must make linguistically appropriate information available to families.

• We revised paragraphs (a) and (b) to provide that the State must ensure that information is made available to applicants, and enrollees.

• We revised paragraph (b) to provide that States must have a mechanism in place to ensure that applicant and enrollees are provided specific information in a timely manner.

Section 457.120

• We added a new paragraph (c) to require that the State plan include a description of the method the State uses to ensure interaction of Indian Tribes and organizations on the implementation of procedures regarding provision of child health assistance to AI/AN children.

Section 457.125

• We revised paragraph (a) by removing language regarding consultation with Indian tribes, which has been incorporated into § 457.120(c).

Section 457.140

• We revised the introductory text of this section to provide that a State plan or State plan amendment must include a 1-year budget.

Section 457.170

• We revised this section to provide more specific rules regarding withdrawal of proposed State plans or plan amendments and withdrawal of approved State plans.

Section 457.190

• We moved the provisions of § 457.190 to new § 457.203.

Subpart C—State Plan Requirements: Eligibility, Screening, Applications and Enrollment

Section 457.301

• We removed our proposed definition of ''employment with a public agency''.

• We added a definition of the term ''joint application''.

Section 457.305

• We revised paragraph (a) to provide that the State plan must include a description of the methodologies used by the State to calculate eligibility under the financial need standard.

• We added a new paragraph (b) to clarify that the State plan must describe the State's policies governing enrollment and disenrollment, including enrollment caps, and processes for instituting waiting lists, deciding which children will be given priority for enrollment, and informing individuals of their status on a waiting list.

Section 457.310

• We revised the financial need standard for a targeted low-income child at paragraph (b)(1).

• We revised paragraph (b)(2)(ii) to provide that a child would not be considered covered under a group health plan if the child did not have reasonable geographic access to care under that plan.

• We revised paragraph (c)(1)(ii) to clarify our policy concerning contributions toward the cost of dependent coverage.

Section 457.320

• We revised paragraph (b)(3) to specifically prohibit discrimination on the basis of diagnosis.

• We revised paragraph (c) to permit States to accept self-declaration of citizenship, provided that the State has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of their application process with respect to self-declaration of citizenship.

• We revised paragraph (a)(7) and added a new paragraph (d) to address eligibility standards related to residency.

• We revised paragraph (a)(10) and added a new paragraph (e) regarding duration of eligibility.

Section 457.340

• We removed proposed § 457.340 and renamed this section, ''Application for and enrollment in a separate child health program.'' This section sets forth provisions regarding application assistance, notice of rights and responsibilities, timely determinations of eligibility, notice of decisions concerning eligibility, and effective date of eligibility.

Section 457.350

• We have revised this section for consistent use of the terms ''found eligible'' and ''potentially eligible''.

• We removed the provisions of proposed paragraph (b) regarding screening with joint applications.

• We redesignated proposed paragraph (c) as paragraph (b) and proposed paragraph (d) as paragraph (c)

• We revised paragraph (b) (proposed paragraph (c)) to require that a State must use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty level related groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act, applying whichever standard and corresponding methodology generally results in a higher income eligibility level for the age group of the child being screened.

• We added a new paragraph (d) to provide that if a State applies a resource test and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing the family's resources to the appropriate Medicaid standard.

• We have clarified the provisions of paragraph (e) (now paragraph (f)) regarding children found potentially eligible for Medicaid.

• We added new paragraphs (g) and (h) to specify requirements regarding informed application decisions and waiting lists, enrollment caps and closed enrollment.

Section 457.353

• We added a new section, ''Evaluation of screening process and provisional enrollment.'' This section sets forth requirements regarding monitoring and evaluations of the screen and enroll process, provisional enrollment during the screening process, and expenditures for coverage during a period of provisional enrollment.

Section 457.360

• We removed this section.

Section 457.365

• We removed the provisions of proposed § 457.365, regarding grievances and appeals, and incorporated them into new subpart K.

Section 457.380 (proposed § 457.970)

• We moved the provisions of proposed § 457.970 to new § 457.380.

• We removed the provision at proposed § 457.970(d) that the State may terminate the eligibility of an applicant or beneficiary for ''good cause.''

Subpart D—Coverage and Benefits: General Provisions

Section 457.402

• We revised § 457.402(a) to list surgical services separately at paragraph (a)(4).

• We moved the definitions of ''emergency medical condition,'' ''emergency services,'' and ''health benefits coverage,'' which were set forth at proposed paragraphs (b), (c), and (e) respectively, to § 457.10.

Section 457.410

• We revised paragraph (b)(1) to provide that the State must obtain coverage for well-baby and well-child care services as defined by the State.

• We revised paragraph (b)(2) to provide that the State must obtain coverage for age-appropriate immunizations.

Section 457.430

• We revised § 457.430 by clarifying that benchmark-equivalent health benefits coverage must meet the requirements of § 457.410(b) and by removing proposed paragraph (b)(4) regarding well-baby and well-child care and immunizations.

Section 457.440

• We revised paragraph (b)(2) to clarify that a State must submit an actuarial report when it amends its existing State-based coverage.

Section 457.450

• We revised paragraph (a) to provide that Secretary-approved coverage may include coverage that is the same as the coverage provided to children under the Medicaid State plan.

Section 457.490

• We revised § 457.490(a) to provide that the State must describe the methods of delivery of child health assistance including the methods for assuring the delivery of the insurance products and the delivery of health care services covered by such products to the enrollees, including any variations.

Section 457.495

• We removed the provisions of proposed § 457.495 regarding grievances and appeals and incorporated them into new subpart K.

• We moved the provisions of proposed § 457.735 to § 457.495, and renamed the section, ''State assurance of access to care and procedures to assure quality and appropriateness of care''.

Subpart E—State Plan Requirements: Beneficiary Financial Responsibilities

Section 457.500

• We added a new paragraph (a)(1) to add section 2101(a) of the Act to the statutory authority for this subpart.

• We revised paragraph (c) to remove the provision that, with respect to a mandatory cost-sharing waiver for AI/AN children, subpart E applies to a Medicaid expansion program.

Section 457.505

• We added a new paragraph (c) to § 457.505 to provide that the State plan must include a description of the State's disenrollment protections as required under § 457.570.

Section 457.510

• We revised paragraph (d) to provide that when a State imposes premiums, enrollment fees, or similar fees, the State plan must describe the consequences for an enrollee or applicant who does not pay a charge and the disenrollment protections adopted by the State.

Section 457.515

• We revised paragraph (d) to provide that the State plan must describe the consequences for an enrollee who does not pay a charge and the disenrollment protections adopted by the State.

• We removed the statement from paragraph (e) the a methodology that primarily relies on a refund is not an acceptable methodology.

Section 457.520

• We revised § 457.520(b) to provide that for the purposes of cost sharing, well-baby and well-child care services include routine examinations as recommended by the AAP's ''Guidelines for Health Supervision III'', or as described in ''Bright Futures: Guidelines for Health and Supervision of Infants, Children and Adolescents,'' Laboratory tests associated with the well-baby and well-child routine physical examinations, and immunizations as recommended and updated by ACIP.

Section 457.525

• We redesignated proposed paragraph (a)(4) as paragraph (a)(5) and revised this paragraph to provide that the public schedule must include information about consequences for an applicant or an enrollee who does not pay a charge including disenrollment protections.

• We added a new paragraph (a)(4) to provide that the public schedule must include information on mechanisms for making payments for required charges.

• We revised paragraph (b)(1) to require States to provide the public schedule to SCHIP enrollees at the time of reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.

Section 457.535

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians and Alaska Natives, as defined in § 457.10.

Section 457.540

• We redesignated proposed paragraphs 457.550(a) and (b) as paragraphs 457.540(d) and (e).

• We redesignated proposed paragraph (e) as paragraph (f).

Section 457.545

• We removed the provisions of this section.

Section 457.550

• We eliminated this section and incorporated its contents into other sections of this subpart.

• We redesignated paragraphs (a) and (b) as § 457.540(d) and (e).

• We redesignated paragraph (c) as § 457.555(e).

Section 457.555

• We revised § 457.555(b) to indicate that cost sharing may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system for the first day of care in the institution.

• We added a new paragraph (c) to provide that any copayment that the State imposes on services provided by an institution to treat an emergency medical condition may not exceed $5.00.

• We redesignated proposed paragraph (c) as paragraph (d).

• We removed proposed paragraph (d) regarding emergency room services provided outside and enrollee's managed care network.

Section 457.560

• We reorganized this section for clarity.

Section 457.565

• We eliminated this section, as it has been incorporated into new subpart K.

Section 457.570

• We added the requirement, at paragraph (b), that the disenrollment process must afford the enrollee's family the opportunity to show that his or her income has declined prior to disenrollment for nonpayment of cost-sharing and charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

• We added the requirement, at paragraph (c), that the State must provide the enrollee with an opportunity for an impartial review to address disenrollment from the program.

Subpart G—Strategic Planning

Section 457.710

• We added a new paragraph (e) to provide that the State's strategic objectives, performance goals and performance measures must include a common core of national performance goals and measures consistent with the data collection, standard methodology, and verification requirements, as developed by the Secretary.

Section 457.735

• We moved the provisions of proposed § 457.735 to § 457.495.

Section 457.740

• We revised paragraph (a) to provide that Territories are exempt from the definition of ''State'' for purposes of quarterly reporting.

• We redesignated proposed paragraph (a)(2) as paragraph (a)(3) and added an new paragraph (a)(2) to

provide that the quarterly reports must include data on a ''point-in-time'' enrollment count as of the last day of each quarter of the Federal fiscal year.

• We added a new paragraph (a)(3)(ii) to provide that the quarterly report must include data on the number of children enrolled in Medicaid by gender, race, and ethnicity.

Section 457.750

• We revised paragraph (b)(1) to provide that in the annual report, the State must include information related to a core set of national performance goals and measures as developed by the Secretary.

• We added a new paragraph (b)(7) to provide that the annual report must include data regarding the primary language of SCHIP enrollees.

• We added a new paragraph (b)(8) to provide that the annual report must describe the State's current income standards and methodologies for its Medicaid expansion program and separate child health program as appropriate.

• We revised paragraph (c) to set forth requirements regarding the State's annual estimate of changes in the number of uninsured children in the State.

Section 457.760

• We removed this section.

Subpart H—Substitution of Coverage

Section 457.810

• We added introductory text to paragraph (a).

• We revised paragraph (a)(1) to provide that an enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

• We revised paragraph(a)(2) to specify the circumstances in which States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan.

• We removed proposed paragraph (a)(3), which specified that a newborn is not required to have a period without insurance as a condition of eligibility for payment for employer-sponsored group health coverage.

• We added a new paragraph (a)(3) to require that the requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan through Medicaid under section 1906 of the Act.

• We added a new paragraph (a)(4) to specify that the Secretary may revise the 6-month waiting period requirement at her discretion.

• We revised paragraph (b) to provide that for health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

• We also removed paragraph (b)(1), which included the minimum 60 percent employer contribution requirement.

Subpart I—Program Integrity

Section 457.902

• We added a definition of the term ''actuarilly sound principles''.

• We moved the definition of ''managed care entity'' to § 457.10.

• We eliminated the definitions of ''contractor'', ''grievance'' and ''State program integrity unit''.

Section 457.920

• We removed this section.

Section 457.940

• We revised paragraph (b)(2) to provide that a State must provide child health assistance in an effective and efficient manner by using payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness.

Section 457.950

• We revised paragraph (a)(3) to provide that a State must ensure that its contract with an MCE provides access for the State, HCFA, and the HHS Office of the Inspector General to enrollee health claims data and payment data.

• We redesignated proposed paragraph (b)(2) as paragraph (b)(3).

• We added a new paragraph (b)(2) to provide that a State that makes payments to fee-for-service entities under a separate child health program must ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws.

Section 457.955

• We added a new paragraph (b)(2) to provide that States must ensure that MCEs are prohibited from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity.

Section 457.970

• We removed this section and incorporated its provisions into § 457.380.

Section 457.975

• We removed this section.

Section 457.985

• We removed this section and incorporated its provisions into new subpart K.

sbull; We added a new § 457.985, Integrity of professional advice to enrollees.

Section 457.990

• We removed this section and incorporated its provisions into new subpart K.

Section 457.995

• We removed this section and incorporated its provisions into new subpart K.

Subpart J—Allowable Waivers: General Provisions

Section 457.1000

• We revised paragraph (c) to provide that this subpart applies to a Medicaid expansion program when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

Section 457.1003

• We added a new § 457.1003 to provide that HCFA will review the waivers in this subpart as State plan amendments under the same timeframes for State plan amendments specified in subpart A.

Section 457.1005

• We revised § 457.1005(c) to provide that an approved waiver for cost-effective coverage through a community-based health delivery system remains in effect for no more than 3 years.

Section 457.1015

• We removed the requirement at paragraph (b)(2) regarding demonstrating cost-effectiveness through comparison with a child-only health benefits package.

Subpart K—Applicant and Enrollee Protections

• We relocated certain provisions involving applicant and enrollee

protections to this new subpart K, ''Applicant and Enrollee Protections.'' Specifically, we moved to this subpart proposed § 457.985, which set forth requirements relating to grievances and appeals, and proposed § 457.990, which set forth requirements for privacy protections.

• We added the following sections in response to public comment: § 457.1140, Core elements of review; § 457.1170, Continuation of Benefits; and § 457.1190, Premium assistance for group health plans.

• The following table shows the disposition of the sections set forth in the proposed rule that have been incorporated into subpart K.

Proposed regulations	Final regulations
Definitions—Contractor.	
457.902	Deleted.
Definitions—Grievance.	
457.902	Deleted.
Denial, Suspension, or Termination of Eligibility	Revised 457.1130(a).
457.365	Revised 457.1130(b).
Reduction or Denial of Services	Revised 457.1130(a).
457.495	Revised 457.1180.
Disenrollment for Failure to Pay Cost Sharing	Revised 457.1130(a) and 457.1180.
	Revised 457.1130(a) and 457.1180.
457.565	Revised 457.1130(b) and 457.1180.
Enrollees Rights to File Grievances and Appeals	Revised 457.1120, 1150(b), and 457.1160.
	Deleted.
	Deleted.
457.985(a)	Deleted.
	Deleted.
457.985(a)(1)	Deleted.
	Revised 457.985, Cross Reference 457.110(b)(5).
457.985(a)(2)	Revised 457.985, Cross Reference 457.110(b)(5).
457.985(a)(3)	Revised 457.1110(b).
	Revised 457.1110.
457.985(b)	Revised 457.1110(a) and (d).
	Revised 457.1110(a) and (d).
457.985(c)	Revised 457.1110(a).
	Revised 457.1110(a).
457.985(c)(1)	Revised 457.1110(c) and (e).
	Revised 457.1110(a).
457.985(c)(2)	Deleted.
	Deleted.
457.985(d)	Deleted.
457.985(e)	Revised 457.1110(e).
457.985(e)(1)	Revised 457.1120 and 457.1180, Cross Reference 457.110(b)(6).
	Revised 457.1130(a).
457.985(e)(2)	Revised 457.1130(b).
Privacy Protections	Revised 457.1130(a)(3).
	Revised 457.1160.
457.990(a).	

F. Technical Corrections

In this final rule we are making the following technical corrections to subpart B, General Administration, and subpart F, Payments to States, of part 457. These subparts were published in final on May 24, 2000 (65 FR 33616).

Subpart B—General Administration—Reviews and Audits; Withholding for Failure To Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments

• We moved the provisions of proposed § 457.190 regarding administrative and judicial review to new § 457.203, as we believe these provisions are more appropriately located in subpart B.

• We revised § 457.204(d)(2) to clarify the meaning of the term ''corrective action.''

• We revised § 457.208(a) to cross refer to the provisions of new § 457.203.

• We removed § 457.234, State plan requirements, as these provisions duplicate § 457.50.

Subpart F—Payments to States

• We removed § 457.624, Limitations of certain payments for certain expenditures, as paragraphs (a) and (b) of this section duplicate the provisions of §§ 457.475 and 457.1010, respectively.

IV. Regulatory Impact Analysis

A. Impact Statement

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.

This final rule does not establish the SCHIP allotment amounts. However, it provides for the implementation and administration of the SCHIP program, and as such, is an economically significant, major rule.

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandate Reform Act of 1995 (Pub. L. 104–4), and the Regulatory Flexibility Act (RFA) (Pub. L. 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulations are

necessary, to select regulatory approaches that maximize net benefits (including potential economic environments, public health and safety, other advantages, distributive impacts, and equity).

The Unfunded Mandates Reform Act of 1995 requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year. Because participation in the SCHIP program on the part of States is voluntary, any payments and expenditures States make or incur on behalf of the program that are not reimbursed by the Federal government are made voluntarily. These regulations implement narrowly defined statutory language and would not create an unfunded mandate on States, tribal or local governments.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain rural counties adjacent to urban areas, 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.

In addition, for purposes of the RFA, we prepare a regulatory flexibility analysis unless we certify that a rule will not have a significant economic impact on a substantial number of small entities. Small entities include small businesses, non-profit organizations, and governmental agencies. Most hospitals and other providers and suppliers are small entities, either by non-profit status or by having revenues of $5 million or less annually. Individuals and State agencies are not included in the definition of small entity. As discussed in detail below, this final rule will have a beneficial impact, if any, on health care providers.

Therefore, we are not preparing an analysis for section 1102(b) of the Act because we have determined, and we certify, that this rule will not have a significant impact on a substantial number of small entities or on the operations of a substantial number of small rural hospitals.

B. Cost Benefit Analysis

This analysis addresses a wide range of costs and benefits of this rule. Whenever possible, we express impact quantitatively. In cases where quantitative approaches are not feasible, we present our best examination of determinable costs, benefits, and associated issues. This final regulation would implement all programmatic provisions of the State Children's Health Insurance Program (SCHIP) including provisions regarding State plan requirements, benefits, eligibility, and program integrity, which are specified in title XXI of the Act. This final regulation would have a beneficial impact in that it would allow States to expand the provision of health benefits coverage to uninsured, low-income children who previously had limited access to health care.

SCHIP is the largest single expansion of health insurance coverage for children since the creation of Medicaid in 1965. SCHIP was designed to reach children from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. As discussed in detail below, this initiative set aside $40 billion over ten years for States to provide new health coverage for millions of children. To date, plans prepared by all 50 States, 5 U.S. territories, and the District of Columbia have been approved. We estimate that States enrolled at least 3 million children in fiscal year 2000. The implementation of SCHIP has significantly reduced the number of uninsured children nationwide. Previously uninsured children now have access to a range of health care services including well baby and well child care, immunizations, and emergency services. In addition to the obvious benefit of providing access to health care coverage for millions of children, as discussed in detail below, SCHIP will also have a beneficial impact on the private sector.

1. Disbursement of Federal Funds

Budget authority for title XXI is specified in section 2104(a) of the Act with additional funding authorized in Pub. L. 105–100. The total national amount of Federal funding available for allotment to the 50 States, the District of Columbia, and the Commonwealths and Territories for the life of SCHIP, is established as follows:

TOTAL AMOUNT OF ALLOTMENTS

Fiscal year	Amount
1998	$4,295,000,000
1999	4,275,000,000
2000	4,275,000,000
2001	4,275,000,000
2002	3,150,000,000
2003	3,150,000,000
2004	3,150,000,000
2005	4,050,000,000
2006	4,050,000,000
2007	5,000,000,000

Under Public Law 105–277, an additional $32 million was appropriated for allotment only to the Commonwealths and Territories, and only for FY 1999. In addition, we note that there was an additional allocation of $20 million in FY 1998, which increases the FY 1998 total allotment amount to $4.295 billion. Also, for each of the first five years, $60 million of the allotment must be used for the special diabetes programs.

Section 702 of the Balanced Budget Refinement Act of 1999 (Pub. L. 106–113, BBRA) appropriated an additional $249 million for Territories. In addition, section 703(c) of the BBRA requires that the Secretary conduct an independent evaluation of 10 States with approved child health plans and appropriates $10 million for FY 2000 for this purpose. The additional allotments for Territories are established as follows:

INCREASED ALLOTMENTS FOR TERRITORIES

Fiscal Year	Amount
2000	$34,200,000
2001	34,200,000
2002	25,200,000
2003	25,200,000
2004	25,200,000
2005	32,400,000
2006	32,400,000
2007	40,000,000

We note that the Federal spending levels for the SCHIP program are based entirely on the spending and allocation formulas contained in the statute. The Secretary has no discretion over these spending levels and initial allotments of funds allocated to States. Both direct program and administrative costs are covered by the allotments.

2. Impact on States

SCHIP is a State-Federal program under which funds go directly to States, which have great flexibility in designing their programs. Specifically, within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages,

payment levels for coverage and administrative and operating procedures. As such, it is difficult to quantify the economic impact on States beyond the obvious benefit of additional funding provided at an ''enhanced'' matching rate as compared to the matching rates for the Medicaid program. As stated above, the total Federal payments available to States are specified in the statute and are allocated according to a statutory formula based on the number of uninsured, low-income children for each State, and a geographic adjustment factor. For qualifying expenditures, States will receive an enhanced Federal matching rate equal to its current FMAP increased by 30 percent of the difference between its regular matching rate and 100 percent, except that the enhanced match cannot exceed 85 percent.

The following chart depicts estimated outlays for the SCHIP program. These estimates differ from the allotments referred to above in that the allotments allow the money to be spent over a period of three years.

FISCAL YEAR OUTLAYS

[In billions]

	1999	2000	2001	2002	2003
Federal share	0.6	1.3	1.9	2.5	3.0
State share	0.2	0.6	0.8	1.1	1.3
Total	0.8	1.9	2.7	3.6	4.3

Note: These estimates are based on State and Federal budget projections and have been included in the President's FY 2001 budget. Outlay estimates do not include costs for Medicaid expansion programs but only for separate child health programs.

Because the final rule largely confirms the provisions in the proposed rule, which were based on previously released guidance, most States' programs are already in compliance with these Federal requirements. In addition, this final rule includes a balance of provisions that provide additional flexibility for States with further clarification of the intent of the statute. Therefore, coupled with the fact that States are working with a limited amount of funds, we do not anticipate that the publication of this rule will have a significant or unexpected impact on States.

3. Impact on the Private Sector

We note that due to the flexibility that States have in designing and implementing their SCHIP programs it is not possible to determine the impact on individual providers groups of providers, insurers, health plans, or employers. However, we anticipate that the SCHIP program will benefit the private sector in a number of ways. The program may have a positive impact on a number of small entities given that SCHIP funding will filter down to health care providers and health plans that cover the SCHIP population. Health plans that provide insurance coverage under the SCHIP program will benefit to the extent that children are generally a lower-risk population. That is, children tend to use fewer high-cost health care services than older segments of the population. Thus, by providing health insurance coverage for preventive care such as well-baby and well-child care and immunizations, SCHIP may benefit health insurers by reducing the need to provide more costly health care services for serious illnesses. Additionally, because SCHIP provides health insurance coverage to children who were previously uninsured, health care providers will no longer have to absorb the cost of uncompensated care for these children. The private sector may also benefit from SCHIP to the extent that children and families with health insurance coverage are more likely to use health care services. Thus, health care providers are likely to experience an increase in demand for their services. Small businesses that are unable to afford private health insurance for their employees will benefit to the extent that the employees, or their children qualify for SCHIP. However, because States have largely been operating their SCHIP programs in accordance with the proposed rule since the beginning of their programs, we do not anticipate the final rule will have a significant impact on the private sector, with the exception of the potential for additional program expansions.

4. Impact on Beneficiaries

The main goal of SCHIP is to provide health insurance coverage for children in families that are not eligible for Medicaid, but do not earn enough to afford private health insurance. SCHIP will allow a large number of children who were previously uninsured to have access to health insurance and the opportunity to receive health care services on a regular basis.

Subpart E of this final rule sets forth provisions regarding the costs that beneficiaries may incur (cost sharing) under SCHIP. In accordance with the statute, we set forth provisions concerning general cost sharing protection for lower income children and American Indians/Alaska Natives, cost sharing for children from families with certain income levels, and cumulative cost-sharing maximums. Section 457.555 sets forth maximum allowable cost sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL. This section specifies maximum copayment amounts that may be imposed under fee-for-service delivery systems and managed care organizations. Additionally, regarding cumulative cost sharing maximums, § 457.560 provides that cost sharing for children with family income above 150 percent of the Federal poverty level may not exceed 5 percent of total family income for the year. For children with family income at or below 150 percent of the Federal poverty level, cost sharing may not exceed 2.5 percent of total family income for the year.

We note that due to State flexibility in establishing cost-sharing amounts below the maximums and differing utilization patterns among beneficiaries, it is difficult to quantify the amount of cost sharing that families incur to participate in SCHIP. However, in light of the number of children enrolled in SCHIP, we believe that for most beneficiaries, the benefit of access to health insurance coverage outweighs the costs associated with participation in the program.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

We received the following comment on the impact analysis:

Comment: Several commenters believe that the regulation is administratively burdensome. Specifically, commenters asserted that the administrative funding for SCHIP is insufficient to effectively operate a State plan under the proposed regulations. The proposed rule fails to adequately acknowledge that State budgets for outreach and administrative activities are limited to 10 percent of total expenditures. Commenters believe this method of computing the administrative cap places States in a difficult position because in order to increase enrollment (and consequently the State's total expenditures), States must incur expenditures for outreach. Commenters recommended that we exclude outreach expenditures from the 10 percent cap.

Commenters also noted that the proposed regulations create additional administrative burdens that do not improve services and may force States to revise programs at additional costs to States. They indicated that for Medicaid expansion programs, Federally required systems changes are matched at 90 percent with no cap. However, the proposed regulations do not offer a similar provision for separate child

health programs required to make changes to existing systems. Additionally, separate child health programs are required to absorb these costs within the limited 10 percent administrative cap.

Commenters strongly recommended that we carefully consider the administrative feasibility and the cost of the proposed regulations for SCHIP eligibles and their families, States and MCEs. Commenters argued that the burden of high administrative costs will be particularly difficult for health plans to bear because per enrollee revenues are comparatively small under SCHIP. The commenters suggested that we evaluate carefully the costs and benefits of administrative requirements to avoid threatening the economic viability of SCHIP programs. The participation of private health plans can offer significant advantages in providing attractive plans for beneficiaries, organizing provider networks, controlling costs and delivering innovations from the employer-based market. However, the low cap on administrative expenses has served to deter some private plans from participating in SCHIP programs. Some private health plans have found it difficult to forecast the financial risk associated with covering children under this program and are concerned that they cannot provide for adequate reserves under the cap.

Response: Under section 2105(c)(2)(A) of the Act, States may receive funds at the enhanced FMAP for administrative expenditures, outreach, health services initiatives, and certain other child health assistance, only up to a ''10 Percent Limit.'' The ''10 Percent Limit'' found in the statute specifies that the ''total computable'' amount of these expenditures (the combined total State and Federal share of benefit and administrative expenditures) for which FFP may be claimed cannot exceed 10 percent of the sum of the total computable expenditures made under section 2105(a) of the Act and the total computable expenditures based on the enhanced match made under sections 1905(u)(2) and (u)(3) of the Act.

It is important to note that States may mitigate the effect of little or no program expenditures on the calculation of the 10 percent limit in one fiscal year by delaying the claiming of administrative expenditures until a subsequent fiscal year. In that case, the delayed administrative expenditures could be applied against the subsequent year's 10 percent limit, which may be calculated using presumably higher program expenditures. This should prove helpful to States now that their programs are up and running and the original start up costs are diminishing. In addition, as States gain more experience operating their programs, administrative costs should fall below the 10 percent cap on administrative expenditures.

In response to the comment that some health plans have found it difficult to foresee the risk associated with covering children under this program, we have no requirement for plan administrative costs. These costs are subject to negotiations between the individual health plan and the State in a risk based capitated arrangement.

V. Federalism

Under Executive Order 13132, we are required to adhere to certain criteria regarding Federalism in developing regulations. Title XXI authorizes grants to States that initiate or expand health insurance programs for low-income, uninsured children. A State Children's Health Insurance Program (SCHIP) under title XXI is jointly financed by the Federal and State governments and is administered by the States. Within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures. States have great flexibility in designing programs to best meet the needs of their beneficiaries. HCFA works closely with the States during the State plan and State plan amendment approval process to ensure that we reach a mutually agreeable decision.

Federal payments under title XXI to States are based on State expenditures under approved plans that could be effective on or after October 1, 1997. The short time frame between the enactment of the Balanced Budget Act (BBA) (August 5, 1997) and the availability of the funding for States required the Department to begin reviewing SCHIP plans submitted by States and Territories at the same time as it was issuing guidance to States on how to operate the SCHIP programs. The Department worked closely with States to disseminate as much information as possible, as quickly as possible, so States could begin to implement their new programs expeditiously.

To be more specific, the Department began issuing guidance to States within one month of enactment of the BBA. We provided information on each State's allotment through two **Federal Register** notices published on September 12, 1997 (62 FR 48098) and February 8, 1999 (64 FR 6102). We developed a model application template to assist State's in applying for title XXI funds. We provided over 100 answers to frequently asked questions. We issued policy guidance through a series of 23 letters to State health officials. All of this information is currently available on our website located on the Internet at *http://www.hcfa.gov.* We have also provided technical assistance to all States in development of SCHIP applications.

On November 8, 1999 we published in the **Federal Register** a proposed rule that set forth all programmatic provisions for SCHIP (64 FR 60882). We received 109 timely comments on the proposed rule. Interested parties that commented included States, enrollee advocate organizations, individuals, and provider organizations. The comments received varied widely and were often very detailed. We received a significant number of comments on the following areas: State plan issues, such as when an amendment to an existing plan is needed; the exemption to cost sharing for American Indian/Alaska Native children; eligibility ''screen and enroll'' requirements; Medicaid coordination issues; eligibility simplification options such as presumptive eligibility; the definition of a targeted low-income child; substitution of private coverage; data collection on race, ethnicity, gender and primary language; grievance and appeal procedures; and premium assistance for employer-sponsored coverage. In this final rule we provide detailed responses to all issues raised by the commenters.

The final programmatic regulation incorporates much of the guidance that already has been issued to States. As the final regulation builds upon previously released guidance, most of the regulation represents policies that have been in operation for some time and are a result of the consultation process that is required as part of the implementation of SCHIP; specifically, the State plan approval process. In developing the interpretative policies set forth in this final rule, we also listened to the concerns of States through processes other than the State plan process as well, by attending conferences and meeting with various groups representing State and public interests. We consulted with State and local officials in the course of the design and review stages of State proposals, and many of the policies found in the proposed and this final rule are a direct result of these discussions and negotiations with the States. To the extent consistent with the objectives of the statute, to obtain substantial health care coverage for uninsured low-income children in an effective an efficient manner, we have endeavored to preserve State options in implementing

their programs. As we continue to implement the program, we have identified a number of areas in which we further elaborate on previous guidance or implement new policies. A summary of key issues is set forth at section II.A.1 of the preamble to this final rule.

VI. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), agencies are required to provide a 30-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. To fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comments on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirement discussed below. The following sections of this document contain information collection requirements:

Section 457.50—State Plan

In summary, § 457.50 requires a State to submit a child health plan to HCFA for approval. The child health plan is a comprehensive written statement submitted by the State describing the purpose, nature, and scope of its Child Health Insurance Program and giving assurance that it will be administered in conformity with the specific requirements of title XIX (as appropriate), title XXI, and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation in the State program.

The burden associated with this requirement is the time and effort for a State to prepare and submit its child health plan to HCFA for approval. These collection requirements are currently approved by OMB under OMB1 0938–0707.

Section 457.60—Amendments

In summary, § 457.60 requires a State to submit to HCFA for approval an amendment to its approved State plan, whenever necessary, to reflect any changes in; (1) Federal law, regulations, policy interpretations, or court decisions, (2) State law, organization, policy or operation of the program, or (3) the source of the State share of funding.

The burden associated with this requirement is the time and effort for a State to prepare and submit any necessary amendments to its State plan to HCFA for approval. Based upon HCFA's previous experiences with State plan amendments we estimate that on average, it will take a State 80 hours to complete and submit an amendment. We estimate that 10 States/territories will submit an amendment on an annual basis for a total burden of 800 hours.

Section 457.70—Program Options

In summary, § 457.70 requires a State that elects to obtain health benefits coverage through its Medicaid plan to submit an amendment to the State's Medicaid State plan as appropriate, demonstrating that it meets specified requirements in subparts A, B, C, F, G and J of part 457 and the applicable Medicaid regulations.

The burden associated with this requirement is the time and effort for a State to prepare and submit the necessary amendment to its Medicaid State plan to HCFA for approval. Based upon HCFA's previous experiences with State Plan amendments we estimate that on average, it will take a State 2 hours to complete and submit an amendment for HCFA approval. We estimate that 28 States/territories will submit an amendment for a total one-time burden of 56 hours.

Section 457.350—Eligibility Screening

In summary, § 457.350 requires a State that chooses to screen for Medicaid eligibility under the poverty level related groups described in 1902(l) of the Act, to provide written notification to the family if the child is found not to be Medicaid eligible.

The burden associated with this requirement is the time and effort for a State to prepare and provide written notification to the family if the child is found not to be Medicaid eligible. The average burden upon the State to prepare the notice is a one time burden estimated to be 10 hours and that it will take 3 minutes for the State to provide and the family to read the information. We estimate that on average, that each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.360—Facilitating Medicaid Enrollment

In summary § 457.360(c) requires a State to provide full and complete information, in writing to the family (that meets the requirements of (c)(1) through (c)(2) of this section), to ensure that a decision by the family not to apply for Medicaid or not to complete the Medicaid application process represents an informed decision.

The burden associated with this requirement is the time and effort for a State to prepare and provide written notice to the family to ensure that a decision by the family not to apply for Medicaid or not to complete the Medicaid application process represents an informed decision. The average burden upon the State to disseminate a standard notice to the family is estimated to be 3 minutes. We estimate that on average, each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.361—Application for and Enrollment in CHIP

In summary, § 457.361(b) requires a State to inform applicants, at the time of application, in writing and orally if appropriate, about the eligibility requirements and their rights under the program.

The burden associated with this requirement is the time and effort for a State to inform each applicant in writing and orally if appropriate, about the eligibility requirements and their rights and obligations under the program. We estimate the average burden upon the State to disseminate a standard notice to the family is estimated to be 3 minutes. We estimate that on average, each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

In summary, § 457.361(c) requires a State to send each applicant a written notice of the agency's decision on the application and, if eligibility is denied or terminated in accordance with § 457.1170(b) (that is, the specific reason or reasons for the action and an

explanation of the right to request a hearing within a reasonable time).

The burden associated with this requirement is the time and effort for a State to prepare and provide written notice to each applicant of the agency's decision on the application, and if eligibility is denied or terminated, the specific reason or reasons for the action and an explanation of the right to request a hearing within a reasonable time. We estimate that on average, it will take each State 3 minutes to prepare each notice and that each State will be required to provide 1 million notices on an annual basis for a total annual burden of 50,000 hours, per State. Therefore, the total estimated burden is calculated to be 2,700,000 hours on an annual basis.

Section 457.431—Actuarial Report for Benchmark-Equivalent Coverage

In summary, § 457.431 requires a State that wants to obtain approval for benchmark-equivalent benefits coverage described under § 457.430 to submit to HCFA an actuarial report that: (1) Compares the actuarial value of coverage of the benchmark package to the State-designed benchmark-equivalent benefit package; (2) demonstrates through an actuarial analysis of the benchmark-equivalent package that coverage requirements under § 457.430 are met; and (3) meets the requirements of § 457.431(b).

The burden associated with this requirement is the time and effort for a State that wants to obtain approval for benchmark-equivalent benefits coverage described under § 457.430 to prepare and submit its actuarial report to HCFA for approval. We estimate that, on average, it will take a State 40 hours to prepare and submit a report for HCFA approval. We estimate that 6 States/territories will submit a plan for a total burden of 240 hours.

Section 457.440—Existing State-Based Comprehensive Coverage

Under paragraph (b) of this section, a State may modify an existing comprehensive State-based coverage program described in paragraph (a) of the section if, among other items, the State submits an actuarial report when it amends its existing coverage.

The burden associated with this requirement is the time and effort for a State needs to prepare an actuarial report. There are only three States that would have this option; we do not anticipate that more than one of them would modify its program in a given year. It would take that State an average of 40 hours to prepare the report.

Section 457.525—Public Schedule

In summary, § 457.525(b) requires a State to make the public schedule required under paragraph (a) available to:

(1) SCHIP enrollees, at the time of enrollment and reenrollment after a redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.

(2) SCHIP applicants, at the time of application.

(3) All SCHIP participating providers.

(4) The general public.

The burden associated with this requirement is the time and effort for a State to prepare and make available its public schedule available to these four groups. We estimate that on average, it will take each State/Territory 120 minutes to prepare its public schedule and 3 minutes to disseminate no more than 20,000 copies of its schedule on an annual basis for a total annual burden of 1000 hours, per State/Territory. Therefore, the total estimated burden is calculated to be 54,000 hours on an annual basis.

Section 457.570—Disenrollment Protections

Under paragraph (a) of this section, a State must give enrollees reasonable written notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

The burden associated with this requirement is the time and effort for a State to prepare a standardized notice and to fill out and give the enrollees the notice. We estimate that it will take each State four hours to create a notice, for a national burden of 216 hours. We anticipate that it will take no longer than 10 minutes per enrollee to fill out the notice and give it to the enrollee; we estimate that approximately five per cent of enrollees will be given notices. If there are 2.6 million children enrolled, as projected, the burden nationally will be 21,700 hours of burden [(2.6 million $\times$ 5 percent $\times$ 10 minutes) $\div$ 60].

Section 457.740—State Expenditure and Statistical Reports.

In summary, § 457.740 requires a State to submit a report to the Secretary that contains quarterly program expenditures and statistical data, no later than 30 days after the end of each quarter of the federal fiscal year. The burden associated with this requirement is the time and effort for a State to prepare and submit its report to the Secretary. These collection requirements are currently approved by under OMB approval number OMB# 0938–0731, with a current expiration date of 1/31/2002.

In addition § 457.740 requires a State to submit an annual report, thirty days after the end of the Federal fiscal year, of an unduplicated count for the Federal fiscal year of children who are enrolled in the title XIX Medicaid program, and the separate child health and Medicaid-expansion programs, as appropriate, by age, service delivery, and income categories described in paragraphs (a) and (b) of this section.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual report to the Secretary. We estimate that on average, it will take a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

Section 457.750—Annual Report

In summary, § 457.750 requires a State to submit a report to the Secretary by January 1 following the end of each federal fiscal year, on the results of the State's assessment of operation of the State child health plan.

The burden associated with this requirement is the time and effort for a State to prepare and submit its annual report on the results of the State's assessment of operation of the State child health plan. We estimate that on average, it will take a State 40 hours to complete and submit their report. We estimate that 54 States/territories will submit a plan for a total burden of 2160 hours.

Section 457.810—Premium Assistance for Employer-Sponsored Group Health Plans: Required Protections Against Substitution

In summary, § 457.810(d) requires a State that uses title XXI funds to provide premium subsidies under employer-sponsored group health plans to collect information to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage.

The burden associated with this requirement is the time and effort for a State to collect the necessary data to evaluate the amount of substitution that occurs as a result of the subsidies and the effect of subsidies on access to coverage. We estimate that on average, it will take a State 20 hours to collect the necessary data for their evaluation. We estimate that 54 States/territories will submit a plan for a total burden of 1,080 hours.

Section 457.940—Procurement Standards

Under paragraph (a), a State must submit to HCFA a written assurance that title XXI services will be provided in an effective and efficient manner. The burden associated with this requirement is the time and effort for a State to write this assurance. We believe that the time involved will be minimal and assign one hour per State for this requirement.

Section 457.950—Contract and Payment Requirements Including Certification of Payment-Related Information

This section, in paragraph (b), requires a State that makes payments to fee-for-service entities under a separate child health program to—

(1) Establish procedures to certify and attest that information on claim forms is truthful, accurate, and complete.

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from federal and State funds, and that any false claims may be prosecuted under applicable federal or State laws.

(3) Require, as a condition of participation, that fee-for-service entities provide the State, HCFA and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

The burden associated with this requirement is the time and effort for a State to establish procedures. It is also the time and effort required for a fee-for-service entity to certify and attest that information on claim forms is truthful, accurate, and complete and to provide access to the required data to the State, HCFA and/or the HHS Office of the Inspector General. Depending on the situation, we estimate that the time required to complete such a certification would be 8 hours per certification, per year. Therefore, 8 hours × 51 States and Territories for a total burden of 408 hours per year.

Section 457.965—Documentation

In summary, § 457.965 requires a State to include in each applicant's record facts to support the State's determination of the applicant's eligibility for CHIP. While this requirement is subject to the PRA, we believe that the burden associated with this requirement is exempt from the PRA as defined in 5 CFR 1320(b)(3), because this requirement would be imposed in the absence of a Federal requirement.

Section 457.985—Integrity of Professional Advice to Enrollees

Under this section, the State must guarantee, in all contracts for coverage and services, beneficiary access to information, in accordance with §§ 422.208 and 422.210(a) and (b), related to limitations on physician incentives or compensation arrangements that have the effect of reducing or limiting services and information requirements respectively.

The burden associated with this requirement is the time and effort for a State to include this guarantee in its contract(s) and for its contractor(s) to give beneficiaries access. We estimate that it will take a token hour for each State to comply with this requirement. We estimate that it will take each contractor 1 hour to include this assurance in its contracts, however the number of contractors that will be affected cannot be known, as States have flexibility to use contractors as they deem appropriate.

Section 457.1005—Waiver for Cost-Effective Coverage Through a Community-Based Health Delivery System

In summary, § 457.1005 requires a State requesting a waiver for cost-effective coverage through a community-based health delivery system, to submit documentation to HCFA that demonstrates that they meet the requirements of § 457.1005(b)(1) and (b)(2).

The burden associated with this requirement is the time and effort for a State that wants to obtain a waiver to prepare and submit the necessary documentation to HCFA that demonstrates that they meet the requirements of § 457.1005.

We estimate that on average, it will take a State 24 hours to prepare and submit a waiver request for HCFA approval. We estimate that 10 States/territories will submit a request for a total burden of 240 hours.

Section 457.1015—Cost Effectiveness

In summary, § 457.1015 requires a State to report to HCFA in its annual report the amount it spent on family coverage and the number of children it covered. While this requirement is subject to the PRA, the burden associated with this requirement is captured in § 457.750 (Annual report).

Section 457.1180—Notice

Under this section, a State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under § 457.1130, a notice that includes the reasons for the determination; an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, and the manner in which a review can be requested; and the circumstances under which benefits may continue pending review.

The burden associated with this requirement is the time and effort for a State to prepare and give out the notice. We estimate that it will take each State four hours (216 hours nationally) to develop a standardized form into which enrollee-specific information may be inserted and a half hour per enrollee to prepare and give out the notice. We estimate that approximately 10 percent of enrollees will receive a notice under this provision, or 130,000 hours nationally [(2.6 million × 30 minutes × 10 percent) ÷ 60 minutes].

We have submitted a copy of this final rule to OMB for its review of the information collection requirements in §§ 457.50, 457.60, 457.70, 457.350, 457.360, 457.361, 457.431, 457.440, 457.525, 457.740, 457.750, 457.760, 457.810, 457.940, 457.965, 457.985, 457.1005, 457.1015, and 457.1140. 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–2006–P.

And, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Brenda Aguilar, HCFA Medicaid Desk Officer.

List of Subjects

42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and record keeping requirements.

42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs-health, Medicaid, Reporting and record keeping requirements.

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and record keeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs-health, Guam, Medicaid, Puerto Rico, Supplemental Security Income (SSI), Virgin Islands.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Children's Health Insurance Program, Reporting and record keeping requirements.

42 CFR chapter IV is amended as set forth below:

A. Part 431 is amended as follows:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

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

2. A new § 431.636 is added to read as follows:

§ 431.636 Coordination of Medicaid with the State Children's Health Insurance Program (SCHIP).

(a) *Statutory basis.* This section implements—

(1) Section 2102(b)(3)(B) of the Act, which provides that children who apply for coverage under a separate child health plan under title XXI, but are found to be eligible for medical assistance under the State Medicaid plan, must be enrolled in the State Medicaid plan; and

(2) Section 2102(c)(2) of the Act, which requires coordination between a State child health program and other public health insurance programs.

(b) *Obligations of State Medicaid Agency.* The State Medicaid agency must adopt procedures to facilitate the Medicaid application process for, and the enrollment of children for whom the Medicaid application and enrollment process has been initiated in accordance with § 457.350(f) of this chapter. The procedures must ensure that—

(1) The applicant is not required to provide information or documentation that has been provided to the State agency responsible for determining eligibility under a separate child health program under title XXI and forwarded by such agency to the Medicaid agency on behalf of the child in accordance with § 457.350(f) of this chapter;

(2) Eligibility is determined in a timely manner in accordance with § 435.911 of this chapter;

(3) The Medicaid agency promptly notifies the State agency responsible for determining eligibility under a separate child health program when a child who was screened as potentially eligible for Medicaid is determined ineligible or eligible for Medicaid; and

(4) The Medicaid agency adopts a process that facilitates enrollment in a State child health program when a child is determined ineligible for Medicaid at initial application or redetermination.

3. In § 431.865(b), the definition of ''erroneous payments'' is revised to read as follows:

§ 431.865 Disallowance of Federal financial participation for erroneous State payments (for annual assessment periods ending after July 1, 1990).

* * * * *

(b) * * *

Erroneous payments means the Medicaid payment that was made for an individual or family under review who—

(1) Was ineligible for the review month or, if full month coverage is not provided, at the time services were received;

(2) Was ineligible to receive a service provided during the review month; or

(3) Had not properly met enrollee liability requirements prior to receiving Medicaid services.

(4) The term does not include payments made for care and services covered under the State plan and furnished to children during a presumptive eligibility period as described in § 435.1102 of this chapter.

* * * * *

B. Part 433 is amended as follows:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for part 433 is revised to read as follows:

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

2. In § 433.10, the heading of paragraph (c) is republished and a new paragraph (c)(4) is added to read as follows:

§ 433.10 Rates of FFP for program services.

* * * * *

(c) *Special provisions.* * * *

(4) Under section 1905(b) of the Social Security Act, the Federal share of State expenditures described in § 433.11(a) for services provided to children, is the enhanced FMAP rate determined in accordance with § 457.622(b) of this chapter, subject to the conditions explained in § 433.11(b).

3. A new § 433.11 is added to read as follows:

§ 433.11 Enhanced FMAP rate for children.

(a) Subject to the conditions in paragraph (b) of this section, the enhanced FMAP determined in accordance with § 457.622 of this chapter will be used to determine the Federal share of State expenditures, except any expenditures pursuant to section 1923 of the Act for payments to disproportionate share hospitals for—

(1) Services provided to optional targeted low-income children described in § 435.4 or § 436.3 of this chapter; and

(2) Services provided to children born before October 1, 1983, with or without group health coverage or other health insurance coverage, who would be described in section 1902(l)(1)(D) of the Act (poverty-level-related children's groups) if—

(i) They had been born on or after that date; and

(ii) They would not qualify for medical assistance under the State plan in effect on March 31, 1997.

(b) Enhanced FMAP is not available if—

(1) A State adopts income and resource standards and methodologies for purposes of determining a child's eligibility under the Medicaid State plan that are more restrictive than those applied under policies of the State plan (as described in the definition of optional targeted low-income children at § 435.4 of this chapter) in effect on June 1, 1997; or

(2) No funds are available in the State's title XXI allotment, as determined under part 457, subpart F of this chapter for the quarter enhanced FMAP is claimed; or

(3) The State fails to maintain a valid method of identifying services provided on behalf of children listed in paragraph (a) of this section.

C. Part 435 is amended as set forth below:

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

1. The authority citation for part 435 continues to read as follows:

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

2. Section 435.4 is amended by adding a definition of ''optional targeted low-income child,'' in alphabetical order, to read as follows:

§ 435.4 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved; and

(ii) Resides in a State with no Medicaid applicable income level (as defined at § 457.10 of this chapter); or

(iii) Resides in a State that has a Medicaid applicable income level (as defined at § 457.10 of this chapter) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan a under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

* * * * *

3. A new § 435.229 is added to read as follows:

§ 435.229 Optional targeted low-income children.

The agency may provide Medicaid to—

(a) All individuals under age 19 who are optional targeted low-income children as defined in § 435.4; or

(b) Reasonable categories of these individuals.

4. In § 435.910, paragraph (h) is added to read as follows:

§ 435.910 Use of social security number.

* * * * *

(h) *Exception.* (1) A State may give a Medicaid identification number to an applicant who, because of well established religious objections, refuses to obtain a Social Security Number (SSN). The identification number may be either an SSN obtained by the State on the applicant's behalf or another unique identifier.

(2) The term *well established religious objections* means that the applicant—

(i) Is a member of a recognized religious sect or division of the sect; and

(ii) Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number.

(3) A State may use the Medicaid identification number established by the State to the same extent as an SSN is used for purposes described in paragraph (b)(3) of this section.

5. In § 435.1001, paragraph (a) is revised to read as follows:

§ 435.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

6. Section 435.1002 is amended by adding a new paragraph (c) to read as follows:

§ 435.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

§ 435.1007 [Amended]

7. In § 435.1007, in paragraph (a), the second sentence is amended by adding ''and section 1905(u)'' between ''(X)'', and ''of the Act;''.

8. A new subpart L is added to part 435 to read as follows:

Subpart L—Option for Coverage of Special Groups

Sec.

435.1100 Basis and scope.

Presumptive Eligibility for Children

435.1101 Definitions related to presumptive eligibility for children.

435.1102 General rules.

Subpart L—Option for Coverage of Special Groups

§ 435.1100 Basis and scope.

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) Scope. This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

Presumptive Eligibility for Children

§ 435.1101 Definitions related to presumptive eligibility for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care

services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter).

§ 435.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a regular Medicaid application form;

(iii) Within five working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency;

(3) Provide all services covered under the plan, including EPSDT; and

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

D. Part 436 is amended as set forth below:

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

1. The authority citation for part 436 continues to read as follows:

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

2. Section 436.3 is amended by adding a definition of ''optional targeted low-income child,'' in alphabetical order, to read as follows:

§ 436.3 Definitions and use of terms.

* * * * *

Optional targeted low-income child means a child under age 19 who meets the financial and categorical standards described below.

(1) *Financial need.* An optional targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level (as defined in § 457.10 of this chapter); or,

(iii) Resides in a State that has a Medicaid applicable income level (as defined in § 457.10) and has family income that either:

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points (expressed as a percentage of the Federal poverty line); or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under the policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage and State maintenance of effort.* An optional targeted low-income child is not covered under a group health plan or health insurance coverage, or would not be eligible for Medicaid under the policies of the State plan in effect on March 31, 1997; except that, for purposes of this standard—

(i) A child shall not be considered to be covered by health insurance coverage based on coverage offered by the State under a program in operation prior to July 1, 1997 if that program received no Federal financial participation;

(ii) A child shall not be considered to be covered under a group health plan or health insurance coverage if the child did not have reasonable geographic access to care under that coverage.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

3. A new § 436.229 is added to read as follows:

§ 436.229 Optional targeted low-income children.

The agency may provide Medicaid to—

(a) All individuals under age 19 who are optional targeted low-income children as defined in § 436.3; or

(b) Reasonable categories of these individuals.

4. In § 436.1001 paragraph (a) is revised to read as follows:

§ 436.1001 FFP for administration.

(a) FFP is available in the necessary administrative costs the State incurs in—

(1) Determining and redetermining Medicaid eligibility and in providing Medicaid to eligible individuals; and

(2) Determining presumptive eligibility for children and providing services to presumptively eligible children.

* * * * *

5. Section 436.1002 is amended by adding a new paragraph (c) to read as follows:

§ 436.1002 FFP for services.

* * * * *

(c) FFP is available in expenditures for services covered under the plan that are furnished—

(1) To children who are determined by a qualified entity to be presumptively eligible;

(2) During a period of presumptive eligibility;

(3) By a provider that is eligible for payment under the plan; and

(4) Regardless of whether the children are determined eligible for Medicaid following the period of presumptive eligibility.

6. A new subpart L is added to part 436 to read as follows:

Subpart L—Option for Coverage of Special Groups

Sec.

436.1100 Basis and scope.

Presumptive Eligibility for Children

436.1101 Definitions related to presumptive eligibility for children.

436.1102 General rules.

Subpart L—Option for Coverage of Special Groups

§ 436.1100 Basis and scope.

(a) *Statutory basis.* Section 1920A of the Act allows States to provide Medicaid services to children under age 19 during a period of presumptive eligibility, prior to a formal determination of Medicaid eligibility.

(b) *Scope.* This subpart prescribes the requirements for providing medical assistance to special groups who are not eligible for Medicaid as categorically or medically needy.

Presumptive Eligibility for Children

§ 436.1101 Definitions related to presumptive eligibility period for children.

Application form means at a minimum the form used to apply for Medicaid under the poverty-level-related eligibility groups described in section 1902(l) of the Act or a joint form for children to apply for the State Children's Health Insurance Program and Medicaid.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish the regular Medicaid eligibility of a child of the age involved.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Services means all services covered under the plan including EPSDT (see part 440 of this chapter.)

§ 436.1102 General rules.

(a) The agency may provide services to children under age 19 during one or more periods of presumptive eligibility following a determination made by a qualified entity that the child's estimated gross family income or, at the State's option, the child's estimated family income after applying simple disregards, does not exceed the applicable income standard.

(b) If the agency elects to provide services to children during a period of presumptive eligibility, the agency must—

(1) Provide qualified entities with application forms for Medicaid and information on how to assist parents, caretakers and other persons in completing and filing such forms;

(2) Establish procedures to ensure that qualified entities—

(i) Notify the parent or caretaker of the child at the time a determination regarding presumptive eligibility is made, in writing and orally if appropriate, of such determination;

(ii) Provide the parent or caretaker of the child with a Medicaid application form;

(iii) Within 5 working days after the date that the determination is made, notify the agency that a child is presumptively eligible;

(iv) For children determined to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate, that—

(A) If a Medicaid application on behalf of the child is not filed by the last day of the following month, the child's presumptive eligibility will end on that last day; and

(B) If a Medicaid application on behalf of the child is filed by the last day of the following month, the child's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and

(v) For children determined not to be presumptively eligible, notify the child's parent or caretaker at the time the determination is made, in writing and orally if appropriate—

(A) Of the reason for the determination; and

(B) That he or she may file an application for Medicaid on the child's behalf with the Medicaid agency; and

(3) Provide all services covered under the plan, including EPSDT.

(4) Allow determinations of presumptive eligibility to be made by qualified entities on a Statewide basis.

(c) The agency must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized for a child in a given time frame.

E. Part 457 is amended as follows:

PART 457—ALLOTMENTS AND GRANTS TO STATES

1. The authority citation for part 457 continues to read as follows:

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

2. A new subpart A is added to read as follows:

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

Sec.

457.1 Program description.
457.2 Basis and scope of subchapter D.
457.10 Definitions and use of terms.
457.30 Basis, scope, and applicability of subpart A.
457.40 State program administration.
457.50 State plan.
457.60 Amendments.
457.65 Effective date and duration of State plans and plan amendments.
457.70 Program options.
457.80 Current State child health insurance coverage and coordination.
457.90 Outreach.
457.110 Enrollment assistance and information requirements.
457.120 Public involvement in program development.
457.125 Provision of child health assistance to American Indian and Alaska Native children.
457.130 Civil rights assurance.
457.135 Assurance of compliance with other provisions.
457.140 Budget.
457.150 HCFA review of State plan material.
457.160 Notice and timing of HCFA action on State plan material.
457.170 Withdrawal process.

Subpart A—Introduction; State Plans for Child Health Insurance Programs and Outreach Strategies

§ 457.1 Program description.

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorizes Federal grants to States for provision of child health assistance to uninsured, low-income children. The program is jointly financed by the Federal and State governments and administered by the States. Within broad Federal rules, each State decides eligible groups, types and ranges of services, payment levels for benefit coverage, and administrative and operating procedures.

§ 457.2 Basis and scope of subchapter D.

(a) *Basis.* This subchapter implements title XXI of the Act, which authorizes Federal grants to States for the provision of child health assistance to uninsured, low-income children.

(b) *Scope.* The regulations in subchapter D set forth State plan requirements, standards, procedures, and conditions for obtaining Federal financial participation (FFP) to enable States to provide health benefits coverage to targeted low-income children, as defined at § 457.310.

§ 457.10 Definitions and use of terms.

For purposes of this part the following definitions apply:

American Indian/Alaska Native (AI/AN) means—

(1) A member of a Federally recognized Indian tribe, band, or group;

(2) An Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et. seq.; or

(3) A person who is considered by the Secretary of the Interior to be an Indian for any purpose.

Applicant means a child who has filed an application (or who has an application filed on their behalf) for health benefits coverage through the State Children's Health Insurance Program. A child is an applicant until the child receives coverage through SCHIP.

Child means an individual under the age of 19.

Child health assistance means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the services listed at § 457.402.

Combination program means a program under which a State implements both a Medicaid expansion program and a separate child health program.

Cost sharing means premium charges, enrollment fees, deductibles, coinsurance, copayments, or other similar fees that the enrollee has responsibility for paying.

Creditable health coverage has the meaning given the term ''creditable coverage'' at 45 CFR 146.113 and includes coverage that meets the requirements of § 457.410 and is provided to a targeted low-income child.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of a woman or her unborn child;

(2) Serious impairment of bodily function; or

(3) Serious dysfunction of any bodily organ or part.

Emergency services means health care services that are—

(1) Furnished by any provider qualified to furnish such services; and

(2) Needed to evaluate, treat, or stabilize an emergency medical condition.

Enrollee means a child who receives health benefits coverage through SCHIP.

Enrollment cap means a limit, established by the State in its State plan, on the total number of children permitted to enroll in a State's separate child health program.

Family income means income as determined by the State for a family as defined by the State.

Federal fiscal year starts on the first day of October each year and ends on the last day of the following September.

Fee-for-service entity has the meaning assigned in § 457.902.

Group health insurance coverage has the meaning assigned at 45 CFR 144.103.

Group health plan has the meaning assigned at 45 CFR 144.103.

Health benefits coverage means an arrangement under which enrolled individuals are protected from some or all liability for the cost of specified health care services.

Health care services means any of the services, devices, supplies, therapies, or other items listed in § 457.402.

Health insurance coverage has the meaning assigned at 45 CFR 144.103.

Health insurance issuer has the meaning assigned at 45 CFR 144.103.

Health maintenance organization (HMO) plan has the meaning assigned at § 457.420.

Health services initiatives means activities that protect the public health, protect the health of individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children).

Joint application has the meaning assigned at § 457.301.

Low-income child means a child whose family income is at or below 200 percent of the poverty line for the size of the family involved.

Managed care entity (MCE) means an entity that enters into a contract to provide services in a managed care delivery system, including but not limited to managed care organizations, prepaid health plans, and primary care case managers.

Medicaid applicable income level means, with respect to a child, the effective income level (expressed as a percentage of the poverty line) specified under the policies of the State plan under title XIX of the Act (including for these purposes, a section 1115 waiver authorized by the Secretary or under the authority of section 1902(r)(2) of the Act) as of March 31, 1997 for the child to be eligible for medical assistance under either section 1902(l)(2) or 1905(n)(2) of the Act.

Medicaid expansion program means a program under which a State receives Federal funding to expand Medicaid eligibility to optional targeted low-income children.

Optional targeted low-income child has the meaning assigned at § 435.4 (for States) and § 436.3 (for Territories) of this chapter.

Period of presumptive eligibility has the meaning assigned at § 457.301.

Poverty line/Federal poverty level means the poverty guidelines updated annually in the **Federal Register** by the U.S. Department of Health and Human Services under authority of 42 U.S.C. 9902(2).

Preexisting condition exclusion has the meaning assigned at 45 CFR 144.103.

Premium assistance program means a component of a separate child health program, approved under the State plan, under which a State pays part or all of the premiums for a SCHIP enrollee or enrollees' group health insurance coverage or coverage under a group health plan.

Presumptive income standard has the meaning assigned at § 457.301.

Public agency has the meaning assigned in § 457.301.

Qualified entity has the meaning assigned at § 457.301.

Separate child health program means a program under which a State receives Federal funding from its title XXI allotment to provide child health assistance through obtaining coverage that meets the requirements of section 2103 of the Act and § 457.402.

State means all States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands. The Territories are excluded from this definition for purposes of § 457.740.

State Children's Health Insurance Program (SCHIP) means a program established and administered by a State, jointly funded with the Federal government, to provide child health assistance to uninsured, low-income children through a separate child health program, a Medicaid expansion program, or a combination program.

State health benefits plan has the meaning assigned in § 457.301.

State plan means the title XXI State child health plan.

Targeted low-income child has the meaning assigned in § 457.310.

Uncovered or uninsured child means a child who does not have creditable health coverage.

Well-baby and well-child care services means regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children and adolescents as defined by the State. For purposes of cost sharing, the term has the meaning assigned at § 457.520.

§ 457.30 Basis, scope, and applicability of subpart A.

(a) *Statutory basis.* This subpart implements the following sections of the Act:

(1) Section 2101(b), which requires that the State submit a State plan.

(2) Section 2102(a), which sets forth requirements regarding the contents of the State plan.

(3) Section 2102(b), which relates to eligibility standards and methodologies.

(4) Section 2102(c), which requires that the State plan include a description of the procedures to be used by the State to accomplish outreach and coordination with other health insurance programs.

(5) Section 2106, which specifies the process for submission, approval, and amendment of State plans.

(6) Section 2107(c), which requires that the State plan include a description of the process used to involve the public in the design and implementation of the plan.

(7) Section 2107(d), which requires that the State plan include a description of the budget for the plan.

(8) Section 2107(e), which provides that certain provisions of title XIX and title XI of the Act apply under title XXI in the same manner that they apply under title XIX.

(b) *Scope.* This subpart sets forth provisions governing the administration of SCHIP, the general requirements for a State plan, and a description of the process for review of a State plan or plan amendment.

(c) *Applicability.* This subpart applies to all States that request Federal financial participation to provide child health assistance under title XXI.

§ 457.40 State program administration.

(a) *Program operation.* The State must implement its program in accordance with the approved State plan, any approved State plan amendments, the requirements of title XXI and title XIX (as appropriate), and the requirements in this chapter. HCFA monitors the operation of the approved State plan and plan amendments to ensure compliance with the requirements of title XXI, title XIX (as appropriate) and this chapter.

(b) *State authority to submit State plan.* A State plan or plan amendment must be signed by the State Governor, or signed by an individual who has been delegated authority by the Governor to submit it.

(c) *State program officials.* The State must identify in the State plan or State plan amendment, by position or title, the State officials who are responsible for program administration and financial oversight.

(d) *State legislative authority.* The State plan must include an assurance that the State will not claim expenditures for child health assistance prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by HCFA.

§ 457.50 State plan.

The State plan is a comprehensive written statement, submitted by the State to HCFA for approval, that describes the purpose, nature, and scope of the State's SCHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

§ 457.60 Amendments.

A State may seek to amend its approved State plan in whole or in part at any time through the submission of an amendment to HCFA. When the State plan amendment has a significant impact on the approved budget, the amendment must include an amended budget that describes the State's planned expenditures for a 1-year period. A State must amend its State plan whenever necessary to reflect—

(a) Changes in Federal law, regulations, policy interpretations, or

court decisions that affect provisions in the approved State plan;

(b) Changes in State law, organization, policy, or operation of the program that affect the following program elements described in the State plan:

(1) Eligibility standards, enrollment caps, and disenrollment policies as described in § 457.305.

(2) Procedures to prevent substitution of private coverage, including exemptions or exceptions to required eligibility waiting periods without coverage under a group health plan as described in § 457.810.

(3) The type of health benefits coverage offered, consistent with the options described in § 457.410.

(4) Addition or deletion of specific categories of benefits covered under the State plan.

(5) Basic delivery system approach as described in § 457.490.

(6) Cost-sharing as described in § 457.505.

(7) Screen and enroll procedures, and other Medicaid coordination procedures as described in §§ 457.350 and 457.353.

(8) Review procedures as described in §§ 457.1130, 457.1160, 457.1170, 457.1180 and 457.1190.

(9) Other comparable required program elements.

(c) Changes in the source of the State share of funding, except for changes in the type of non-health care related revenues used to generate general revenue.

§ 457.65 Effective date and duration of State plans and plan amendments.

(a) *Effective date in general.* Except as otherwise limited by this section—

(1) A State plan or plan amendment takes effect on the day specified in the plan or plan amendment, but no earlier than October 1, 1997.

(2) The effective date may be no earlier than the date on which the State begins to incur costs to implement its State plan or plan amendment.

(3) A State plan amendment that takes effect prior to submission of the amendment to HCFA may remain in effect only until the end of the State fiscal year in which the State makes it effective, or, if later, the end of the 90-day period following the date on which the State makes it effective, unless the State submits the amendment to HCFA for approval before the end of that State fiscal year or that 90-day period.

(b) *Amendments relating to eligibility or benefits.* A State plan amendment that eliminates or restricts eligibility or benefits may not be in effect for longer than a 60-day period, unless the amendment is submitted to HCFA before the end of that 60-day period. The amendment may not take effect unless—

(1) The State certifies that it has provided prior public notice of the proposed change in a form and manner provided under applicable State law; and

(2) The public notice was published before the requested effective date of the change.

(c) *Amendments relating to cost sharing.* A State plan amendment that implements cost-sharing charges, increases existing cost-sharing charges, or increases the cumulative cost-sharing maximum as set forth at § 457.560 is considered an amendment that restricts benefits and must meet the requirements in paragraph (b) of this section.

(d) *Amendments relating to enrollment procedures.* A State plan amendment that implements a required period of uninsurance, increases the length of existing required periods of uninsurance, or institutes or extends the use of waiting lists, enrollments caps or closed enrollment periods is considered an amendment that restricts eligibility and must meet the requirements in paragraph (b) of this section.

(e) *Amendments relating to the source of State funding.* A State plan amendment that changes the source of the State share of funding can take effect no earlier than the date of submission of the amendment.

(f) *Continued approval.* An approved State plan continues in effect unless—

(1) The State adopts a new plan by obtaining approval under § 457.60 of an amendment to the State plan;

(2) Withdraws its plan in accordance with § 457.170(b); or

(3) The Secretary finds substantial noncompliance of the plan with the requirements of the statute or regulations.

§ 457.70 Program options.

(a) *Health benefits coverage options.* A State may elect to obtain health benefits coverage under its plan through—

(1) A separate child health program;

(2) A Medicaid expansion program; or

(3) A combination program.

(b) *State plan requirement.* A State must include in the State plan or plan amendment a description of the State's chosen program option.

(c) *Medicaid expansion program requirements.* A State plan under title XXI for a State that elects to obtain health benefits coverage through its Medicaid plan must—

(1) Meet the requirements of—

(i) Subpart A;

(ii) Subpart B (to the extent that the State claims administrative costs under title XXI);

(iii) Subpart F (with respect to determination of the allotment for purposes of the enhanced matching rate, determination of the enhanced matching rate, and payment of any claims for administrative costs under title XXI only);

(iv) Subpart G; and

(v) Subpart J (if the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims based on a community based health delivery system).

(2) Be consistent with the State's Medicaid State plan, or an approvable amendment to that plan, as required under title XIX.

(d) *Separate child health program requirements.* A State that elects to obtain health benefits coverage under its plan through a separate child health program must meet all the requirements of part 457.

(e) *Combination program requirements.* A State that elects to obtain health benefits coverage through both a separate child health program and a Medicaid expansion program must meet the requirements of paragraphs (c) and (d) of this section.

§ 457.80 Current State child health insurance coverage and coordination.

A State plan must include a description of—

(a) The extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children, by income level and other relevant factors, currently have creditable health coverage (as defined in § 457.10) and, if sufficient information is available, whether the creditable health coverage they have is under public health insurance programs or health insurance programs that involve public-private partnerships;

(b) Current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships; and

(c) Procedures the State uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children. Such procedures include those designed to—

(1) Increase the number of children with creditable health coverage;

(2) Assist in the enrollment in SCHIP of children determined ineligible for Medicaid; and

(3) Ensure that only eligible targeted low-income children are covered under SCHIP, such as those procedures required under §§ 457.350 and 457.353, as applicable.

§ 457.90 Outreach.

(a) *Procedures required.* A State plan must include a description of procedures used to inform families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs of the availability of the programs, and to assist them in enrolling their children in one of the programs.

(b) *Examples.* Outreach strategies may include but are not limited to the following:

(1) Education and awareness campaigns, including targeted mailings and information distribution through various organizations.

(2) Enrollment simplification, such as simplified or joint application forms.

(3) Application assistance, including opportunities to apply for child health assistance under the plan through community-based organizations and in combination with other benefits and services available to children.

§ 457.110 Enrollment assistance and information requirements.

(a) *Information disclosure.* The State must make accurate, easily understood, linguistically appropriate information available to families of potential applicants, applicants and enrollees, and provide assistance to these families in making informed decisions about their health plans, professionals, and facilities.

(b) *Required information.* The State must make available to potential applicants and provide applicants and enrollees the following information in a timely manner:

(1) Types of benefits, and amount, duration and scope of benefits available under the program.

(2) Cost-sharing requirements as described in § 457.525.

(3) Names and locations of current participating providers.

(4) If an enrollment cap is in effect or the State is using a waiting list, a description of the procedures relating to the cap or waiting list, including the process for deciding which children will be given priority for enrollment, how children will be informed of their status on a waiting list and the circumstances under which enrollment will reopen.

(5) Information on physician incentive plans as required by § 457.985.

(6) Review processes available to applicants and enrollees as described in the State plan pursuant to § 457.1120.

§ 457.120 Public involvement in program development.

A State plan must include a description of the method the State uses to—

(a) Involve the public in both the design and initial implementation of the program;

(b) Ensure ongoing public involvement once the State plan has been implemented; and

(c) Ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required at § 457.125.

§ 457.125 Provision of child health assistance to American Indian and Alaska Native children.

(a) *Enrollment.* A State must include in its State plan a description of procedures used to ensure the provision of child health assistance to American Indian and Alaska Native children.

(b) *Exemption from cost sharing.* The procedures required by paragraph (a) of this section must include an exemption from cost sharing for American Indian and Alaska Native children in accordance with § 457.535.

§ 457.130 Civil rights assurance.

The State plan must include an assurance that the State will comply with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

§ 457.135 Assurance of compliance with other provisions.

The State plan must include an assurance that the State will comply, under title XXI, with the following provisions of titles XIX and XI of the Social Security Act:

(a) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(b) Paragraphs (2), (16) and (17) of section 1903(i) (relating to limitations on payment).

(c) Section 1903(w) (relating to limitations on provider donations and taxes).

(d) Section 1132 (relating to periods within which claims must be filed).

§ 457.140 Budget.

The State plan, or plan amendment that has a significant impact on the approved budget, must include a budget that describes the State's planned expenditures for a 1-year period. The budget must describe—

(a) Planned use of funds, including—

(1) Projected amount to be spent on health services;

(2) Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and

(3) Assumptions on which the budget is based, including cost per child and expected enrollment; and

(b) Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

§ 457.150 HCFA review of State plan material.

(a) *Basis for action.* HCFA reviews each State plan and plan amendment to determine whether it meets or continues to meet the requirements for approval under relevant Federal statutes, regulations, and guidelines furnished by HCFA to assist in the interpretation of these regulations.

(b) *Action on complete plan.* HCFA approves or disapproves the State plan or plan amendment only in its entirety.

(c) *Authority.* The HCFA Administrator exercises delegated authority to review and then to approve or disapprove the State plan or plan amendment, or to determine that previously approved material no longer meets the requirements for approval. The Administrator does not make a final determination of disapproval without first consulting the Secretary.

(d) *Initial submission.* The Administrator designates an official to receive the initial submission of State plans.

(e) *Review process.* (1) The Administrator designates an individual to coordinate HCFA's review for each State that submits a State plan.

(2) HCFA notifies the State of the identity of the designated individual in the first correspondence relating to that plan, and at any time there is a change in the designated individual.

(3) In the temporary absence of the designated individual during regular business hours, an alternate individual will act in place of the designated individual.

§ 457.160 Notice and timing of HCFA action on State plan material.

(a) *Notice of final determination.* The Administrator provides written notification to the State of the approval

or disapproval of a State plan or plan amendment.

(b) *Timing.* (1) A State plan or plan amendment will be considered approved unless HCFA, within 90 calendar days after receipt of the State plan or plan amendment in the HCFA central office, sends the State—

(i) Written notice of disapproval; or

(ii) Written notice of additional information it needs in order to make a final determination.

(2) A State plan or plan amendment is considered received when the designated official or individual, as determined in § 457.150(d) and (e), receives an electronic, fax or paper copy of the complete material.

(3) If HCFA requests additional information, the 90-day review period for HCFA action on the State plan or plan amendment—

(i) Stops on the day HCFA sends a written request for additional information or the next business day if the request is sent on a Federal holiday or weekend; and

(ii) Resumes on the next calendar day after the HCFA designated individual receives an electronic, fax, or hard copy from the State of all the requested additional information, unless the information is received after 5 p.m. eastern standard time on a day prior to a non-business day or any time on a non-business day, in which case the review period resumes on the following business day.

(4) The 90-day review period cannot stop or end on a non-business day. If the 90th calendar day falls on a non-business day, HCFA will consider the 90th day to be the next business day.

(5) HCFA may send written notice of its need for additional information as many times as necessary to obtain the complete information necessary to review the State plan or plan amendment.

§ 457.170 Withdrawal process.

(a) *Withdrawal of proposed State plans or plan amendments.* A State may withdraw a proposed State plan or plan amendment, or any portion of a proposed State plan or plan amendment, at any time during the review process by providing written notice to HCFA of the withdrawal.

(b) *Withdrawal of approved State plans.* A State may request withdrawal of an approved State plan by submitting a State plan amendment to HCFA in accordance with § 457.60.

Subpart B—General Administration—Reviews and Audits; Withholding for Failure to Comply; Deferral and Disallowance of Claims; Reduction of Federal Medical Payments

3. A new § 457.203 is added to read as follows:

§ 457.203 Administrative and judicial review of action on State plan material.

(a) *Request for reconsideration.* Any State dissatisfied with the Administrator's action on State plan material under § 457.150 may, within 60 days after receipt of the notice of final determination provided under § 457.160(a), request that the Administrator reconsider whether the State plan or plan amendment conforms with the requirements for approval.

(b) *Notice of hearing.* Within 30 days after receipt of the request, the Administrator notifies the State of the time and place of a hearing to be held for the purpose of reconsideration.

(c) *Hearing procedures.* The hearing procedures set forth in part 430, subpart D of this chapter govern a hearing requested under this section.

(d) *Effect of hearing decision.* HCFA does not delay the denial of Federal funds, if required by the Administrator's original determination, pending a hearing decision. If the Administrator determines that his or her original decision was incorrect, HCFA will pay the State a lump sum equal to any funds incorrectly denied.

4. Paragraph (d)(2) of § 457.204 is revised to read as follows:

§ 457.204 Withholding of payment for failure to comply with Federal requirements.

* * * * *

(d) * * *

(2) *Opportunity for corrective action.* If enforcement actions are proposed, the State must submit evidence of corrective action related to the findings of noncompliance to the Administrator within 30 days from the date of the preliminary notification. Corrective action is action to ensure that the plan is, and will be, administered consistent with applicable law and regulations, to ameliorate past deficiencies in plan administration, or to ensure that enrollees will be treated equitably.

* * * * *

5. Paragraph (a) of § 457.208 is revised to read as follows:

§ 457.208 Judicial review.

(a) *Right to judicial review.* Any State dissatisfied with the Administrator's final determination on approvability of plan material (§ 457.203) or compliance with Federal requirements (§ 457.204) has a right to judicial review.

* * * * *

§ 457.234 [Removed]

6. Section 457.234 is removed.

7. New subparts C, D, and E are added to read as follows:

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

Sec.

457.300 Basis, scope, and applicability.
457.301 Definitions and use of terms.
457.305 State plan provisions.
457.310 Targeted low-income child.
457.320 Other eligibility standards.
457.340 Application for and enrollment in a separate child health program.
457.350 Eligibility screening and facilitation of Medicaid enrollment.
457.353 Monitoring and evaluation of screening process.
457.355 Presumptive eligibility.
457.380 Eligibility verification.

Subpart D—State Plan Requirements: Coverage and Benefits

457.401 Basis, scope, and applicability.
457.402 Definition of child health assistance.
457.410 Health benefits coverage options.
457.420 Benchmark health benefits coverage.
457.430 Benchmark-equivalent health benefits coverage.
457.431 Actuarial report for benchmark-equivalent coverage.
457.440 Existing comprehensive State-based coverage.
457.450 Secretary-approved coverage.
457.470 Prohibited coverage.
457.475 Limitations on coverage: Abortions.
457.480 Preexisting condition exclusions and relation to other laws.
457.490 Delivery and utilization control systems.
457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

457.500 Basis, scope, and applicability.
457.505 General State plan requirements.
457.510 Premiums, enrollment fees, or similar fees: State plan requirements.
457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.
457.520 Cost sharing for well-baby and well-child care services.
457.525 Public schedule.
457.530 General cost-sharing protection for lower income children.
457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.
457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.
457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

457.560 Cumulative cost-sharing maximum.
457.570 Disenrollment protections.

Subpart C—State Plan Requirements: Eligibility, Screening, Applications, and Enrollment

§ 457.300 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements —

(1) Section 2102 of the Act, which relates to eligibility standards and methodologies, coordination with other health insurance programs, and outreach and enrollment efforts to identify and enroll children who are eligible to participate in other public health insurance programs;

(2) Section 2105(c)(6)(B) of the Act, which relates to the prohibition against expenditures for child health assistance provided to children eligible for coverage under other Federal health care programs other than programs operated or financed by the Indian Health Service; and

(3) Section 2110(b) of the Act, which provides a definition of targeted low-income child.

(b) *Scope.* This subpart sets forth the requirements relating to eligibility standards and to screening, application and enrollment procedures.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program. Regulations relating to eligibility, screening, applications and enrollment that are applicable to a Medicaid expansion program are found at § 431.636, § 435.4, § 435.229, § 435.1102, § 436.3, § 436.229, and § 436.1102 of this chapter.

§ 457.301 Definitions and use of terms.

As used in this subpart—

Joint application means a form used to apply for the separate child health program that, when transmitted to the Medicaid agency following a screening that shows the child is potentially eligible for Medicaid, may also be used to apply for Medicaid.

Qualified entity means an entity that is determined by the State to be capable of making determinations of presumptive eligibility for children, and that—

(1) Furnishes health care items and services covered under the approved plan and is eligible to receive payments under the approved plan;

(2) Is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act;

(3) Is authorized to determine eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990;

(4) Is authorized to determine eligibility of an infant or child to receive assistance under the special nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966;

(5) Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801);

(6) Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs;

(7) Is a State or Tribal child support enforcement agency;

(8) Is an organization that is providing emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act;

(9) Is a State or Tribal office or entity involved in enrollment in the program under Part A of title IV, title XIX, or title XXI; or

(10) Is an entity that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 *et seq.*); or

(11) Any other entity the State so deems, as approved by the Secretary.

Period of presumptive eligibility means a period that begins on the date on which a qualified entity determines that a child is presumptively eligible and ends with the earlier of—

(1) In the case of a child on whose behalf a separate child health program application has been filed, the day on which a decision is made on that application; or

(2) In the case of a child on whose behalf an application for the separate child health program has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made.

Public agency means a State, county, city or other type of municipal agency, including a public school district, transportation district, irrigation district, or any other type of public entity.

Presumptive income standard means the highest income eligibility standard established under the plan that is most likely to be used to establish eligibility of a child of the age involved.

§ 457.305 State plan provisions.

The State plan must include a description of—

(a) The standards, consistent with §§ 457.310 and 457.320, used to determine the eligibility of children for coverage under the State plan.

(b) The State's policies governing enrollment and disenrollment; processes for screening applicant children for and, if eligible, facilitating their enrollment in Medicaid; and processes for implementing waiting lists and enrollment caps (if any).

§ 457.310 Targeted low-income child.

(a) *Definition.* A targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the State under § 457.320.

(b) *Standards.* A targeted low-income child must meet the following standards:

(1) *Financial need standard.* A targeted low-income child:

(i) Has a family income at or below 200 percent of the Federal poverty line for a family of the size involved;

(ii) Resides in a State with no Medicaid applicable income level or;

(iii) Resides in a State that has a Medicaid applicable income level and has family income that either—

(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or

(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.

(2) *No other coverage standard.* A targeted low-income child must not be—

(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at § 457.350); or

(ii) Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a State that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

(3) For purposes of this section, policies of the State plan under title XIX plan include policies under a Statewide demonstration project under section 1115(a) of the Act other than a demonstration project that covered an

expanded group of eligible children but that either—

(i) Did not provide inpatient hospital coverage; or

(ii) Limited eligibility to children previously enrolled in Medicaid, imposed premiums as a condition of initial or continued enrollment, and did not impose a general time limit on eligibility.

(c) *Exclusions.* Notwithstanding paragraph (a) of this section, the following groups are excluded from the definition of targeted low-income children:

(1) *Children eligible for certain State health benefits coverage.* (i) A targeted low-income child may not be eligible for health benefits coverage under a State health benefits plan in the State on the basis of a family member's employment with a public agency, even if the family declines to accept the coverage.

(ii) A child is considered eligible for health benefits coverage under a State health benefits plan if a more than nominal contribution to the cost of health benefits coverage under a State health benefits plan is available from the State or public agency with respect to the child or would have been available from those sources on November 8, 1999. A contribution is considered more than nominal if the State or public agency makes a contribution toward the cost of an employee's dependent(s) that is $10 per family, per month, more than the State or public agency's contribution toward the cost of covering the employee only.

(2) *Residents of an institution.* A child must not be—

(i) An inmate of a public institution as defined at § 435.1009 of this chapter; or

(ii) A patient in an institution for mental diseases, as defined at § 435.1009 of this chapter, at the time of initial application or any redetermination of eligibility.

§ 457.320 Other eligibility standards.

(a) *Eligibility standards.* To the extent consistent with title XXI of the Act and except as provided in paragraph (b) of this section, the State plan may adopt eligibility standards for one or more groups of children related to—

(1) Geographic area(s) served by the plan;

(2) Age (up to, but not including, age 19);

(3) Income;

(4) Resources;

(5) Spenddowns;

(6) Disposition of resources;

(7) Residency, in accordance with paragraph (d) of this section;

(8) Disability status, provided that such standards do not restrict eligibility;

(9) Access to, or coverage under, other health coverage; and

(10) Duration of eligibility, in accordance with paragraph (e) of this section.

(b) *Prohibited eligibility standards.* In establishing eligibility standards and methodologies, a State may *not*—

(1) Cover children with a higher family income without covering children with a lower family income within any defined group of covered targeted low-income children;

(2) Deny eligibility based on a preexisting medical condition;

(3) Discriminate on the basis of diagnosis;

(4) Require that any individual provide a social security number (SSN), including the SSN of the applicant child or that of a family member whose income or resources might be used in making the child's eligibility determination;

(5) Exclude American Indian or Alaska Native children based on eligibility for, or access to, medical care funded by the Indian Health Service;

(6) Exclude individuals based on citizenship or nationality, to the extent that the children are U.S. citizens, U.S. nationals or qualified aliens, (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means-tested public benefits); or

(7) Violate any other Federal laws or regulations pertaining to eligibility for a separate child health program under title XXI.

(c) *Self-declaration of citizenship.* In establishing eligibility for coverage under a separate child health plan, a State may accept self-declaration of citizenship (including nationals of the U.S.), provided that the State has implemented effective, fair, and nondiscriminatory procedures for ensuring the integrity of its application process.

(d) *Residency.* The State may establish residency requirements, except that a State may not—

(1) Impose a durational residency requirement;

(2) Preclude the following individuals from declaring residence in a State—

(i) A non-institutionalized child who is not a ward of the State, if the child is physically located in that State, including as a result of the parent's or caretaker's employment in that State;

(ii) An institutionalized child who is not a ward of a State, if the State is the State of residence of the child's custodial parent's or caretaker at the time of placement;

(iii) A child who is a ward of a State, regardless of the child's physical location; or

(iv) A child whose custodial parent or caretaker is involved in work of a transient nature, if the State is the parent's or caretaker's home State.

(e) *Duration of eligibility.* (1) The State may not impose a lifetime cap or other time limit on the eligibility of an individual applicant or enrollee, based on the length of time such applicant or enrollee has received benefits under the State's separate child health program.

(2) Eligibility must be redetermined at least every 12 months.

§ 457.340 Application for and enrollment in a separate child health program.

(a) *Application assistance.* A State must afford families an opportunity to apply for child health assistance without delay, provided that the State has not reached an approved enrollment cap, and offer assistance to families in understanding and completing applications and in obtaining any required documentation.

(b) *Notice of rights and responsibilities.* A State must inform applicants at the time of application, in writing and orally if appropriate, about the application and eligibility requirements, the time frame for determining eligibility, and the right to review of eligibility determinations as described in § 457.1130.

(c) *Timely determinations of eligibility.* (1) The agency must promptly determine eligibility and issue a notice of decision within the time standards established, except in circumstances that are beyond the agency's control.

(2) A State must establish time standards for determining eligibility. These standards may not exceed forty-five calendar days (excluding days during which the application has been suspended, pursuant to § 457.350(f)(1)).

(3) In applying the time standards, the State must define ''date of application'' and must count each calendar day from the date of application to the day the agency mails or otherwise provides notice of its eligibility decision.

(d) *Notice of decision concerning eligibility.* A State must provide each applicant or enrollee a written notice of any decision on the application or other determination concerning eligibility.

(1) If eligibility is approved, the notice must include information on the enrollee's rights and responsibilities under the program, including the opportunity for review of matters described in § 457.1130.

(2) If eligibility is denied, suspended or terminated, the State must provide

notice in accordance with § 457.1180. In the case of a suspension or termination of eligibility, the State must provide sufficient notice to enable the child's parent or caretaker to take any appropriate actions that may be required to allow coverage to continue without interruption.

(e) *Effective date of eligibility.* A State must specify a method for determining the effective date of eligibility for its separate child health program, which can be determined based on the date of application or through any other reasonable method.

§ 457.350 Eligibility screening and facilitation of Medicaid enrollment.

(a) *State plan requirement.* The State plan must include a description of—

(1) The screening procedures that the State will use, at intake and any follow-up eligibility determination, including any periodic redetermination, to ensure that only targeted low-income children are furnished child health assistance under the plan; and

(2) The procedures that the State will use to ensure that the Medicaid application and enrollment process is initiated and that Medicaid enrollment is facilitated for children found, through the screening process, to be potentially eligible for Medicaid.

(b) *Screening objectives.* A State must use screening procedures to identify, at a minimum, any applicant or enrollee who is potentially eligible for Medicaid under one of the poverty-level-related groups described in section 1902(l) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act, applying whichever standard and corresponding methodology generally results in a higher income eligibility level for the age group of the child being screened.

(c) *Income eligibility test.* To identify the children described in paragraph (b) of this section, a State must either initially apply the gross income test described in paragraph (c)(1) of this section and then use an adjusted income test described in paragraph (c)(2) of this section for applicants whose gross income is above the appropriate Medicaid income standard, or use only the adjusted income test.

(1) *Initial gross income test.* Under this test, a State initially screens for Medicaid eligibility by comparing gross family income to the appropriate Medicaid income standard.

(2) *Adjusted income test.* Under this test, a State screens for Medicaid eligibility by comparing adjusted family income to the appropriate Medicaid income standard. The State must apply Medicaid standards and methodologies relating to income for the particular Medicaid eligibility group, including all income exclusions and disregards, except those that apply only in very limited circumstances.

(d) *Resource eligibility test.* (1) If a State applies a resource test for children under the Medicaid eligibility group used for screening purposes as described in paragraph (b) of this section and a child has been determined potentially income eligible for Medicaid, the State must also screen for Medicaid eligibility by comparing family resources to the appropriate Medicaid resource standard.

(2) In conducting the screening, the State must apply Medicaid standards and methodologies related to resources for the particular Medicaid eligibility group, including all resource exclusions and disregards, except those that apply only in very limited circumstances.

(e) *Children found potentially ineligible for Medicaid.* If a State uses a screening procedure other than a full determination of Medicaid eligibility under all possible eligibility groups, and the screening process reveals that the child does not appear to be eligible for Medicaid, the State must provide the child's family with the following in writing:

(1) A statement that based on a limited review, the child does not appear eligible for Medicaid, but Medicaid eligibility can only be determined based on a full review of a Medicaid application under all Medicaid eligibility groups;

(2) Information about Medicaid eligibility and benefits; and

(3) Information about how and where to apply for Medicaid under all eligibility groups.

(f) *Children found potentially eligible for Medicaid.* If the screening process reveals that the child is potentially eligible for Medicaid, the State must establish procedures in coordination with the Medicaid agency that facilitate enrollment in Medicaid and avoid duplicative requests for information and documentation and must—

(1) Except as provided in § 457.355, find the child ineligible, provisionally ineligible, or suspend the child's application for the separate child health program unless and until a completed Medicaid application for that child is denied, or the child's circumstances change, and promptly transmit the separate child health application to the Medicaid agency as provided in paragraph (f)(3)(ii) of this section; and

(2) If a State uses a joint application for its Medicaid and separate child health programs, promptly transmit the application, or the information obtained through the application, and all relevant documentation to the Medicaid agency; or

(3) If a State does not use a joint application for its Medicaid and separate child health programs:

(i) Promptly inform the child's parent or caretaker in writing and, if appropriate, orally that the child has been found likely to be eligible for Medicaid; provide the family with a Medicaid application and offer information about what, if any, further information, documentation, or other steps are needed to complete the Medicaid application process; and offer assistance in completing the application process;

(ii) Promptly transmit the separate child health program application; or the information obtained through the application, and all other relevant information and documentation, including the results of the screening process, to the Medicaid agency for a final determination of Medicaid eligibility in accordance with the requirements of §§ 431.636 and 457.1110 of this chapter; or

(4) Establish other effective and efficient procedures, in coordination with the Medicaid agency, as described and approved in the State plan that ensure that children who are screened as potentially eligible for Medicaid are able to apply for Medicaid without delay and, if eligible, are enrolled in Medicaid in a timely manner; and

(5) Determine or redetermine eligibility for the separate child health program, if—

(i) The State is notified pursuant to § 431.636 of this chapter that the child has been found ineligible for Medicaid, consistent with the time standards established pursuant to § 457.340(c); or

(ii) The State is notified prior to the final Medicaid eligibility determination that the child's circumstances have changed and another screening shows that the child is not likely to be eligible for Medicaid.

(iii) For purposes of such determination or redetermination, the State must not require the child to complete a new application for the separate child health program, but may require supplemental information to account for any changes in the child's circumstances that may affect eligibility.

(g) *Informed application decisions.* To enable a family to make an informed decision about applying for Medicaid or completing the Medicaid application process, a State must provide the child's family with information, in writing, about—

(1) The State's Medicaid program, including the benefits covered, and restrictions on cost sharing; and

(2) Eligibility rules that prohibit children who have been screened eligible for Medicaid from being enrolled in a separate child health program, other than provisional temporary enrollment while a final Medicaid eligibility determination is being made.

(h) *Waiting lists, enrollment caps and closed enrollment.* The State must establish procedures to ensure that—

(1) The procedures developed in accordance with this section have been followed for each child applying for a separate child health program before placing the child on a waiting list or otherwise deferring action on the child's application for the separate child health program; and

(2) Families are informed that a child may be eligible for Medicaid if circumstances change while the child is on a waiting list for separate child health program.

§ 457.353 Monitoring and evaluation of screening process.

States must monitor and establish a mechanism to evaluate the screen and enroll process described at § 457.350 to ensure that children who are screened potentially eligible for Medicaid are enrolled in Medicaid, if eligible, and that children who are found ineligible for Medicaid are enrolled in the separate child health program, if eligible.

§ 457.355 Presumptive eligibility.

Consistent with subpart D of this part, the State may pay costs of coverage under a separate child health program, during a period of presumptive eligibility for children applying for coverage under the separate child health program, pending the screening process and a final determination of eligibility (including applicants found through screening to be potentially eligible for Medicaid)

(a) *Expenditures for coverage during a period of presumptive eligibility.* (1) Expenditures for coverage during a period of presumptive eligibility for a child ultimately determined eligible for the separate child health program, will be considered, for that period, as expenditures for child health assistance for targeted low-income children under the plan.

(2) Expenditures for coverage during a period of presumptive eligibility implemented in accordance with § 435.1101 of this part for a child ultimately determined ineligible for both the separate child health program and Medicaid for that period, and for a child whose family does not complete the Medicaid application process, will be considered as expenditures for targeted low-income children under the plan.

(3) Expenditures for coverage during a period of presumptive eligibility for a child ultimately determined to be eligible for Medicaid may not be considered expenditures under the separate child health program.

§ 457.380 Eligibility verification.

(a) The State must establish procedures to ensure the integrity of the eligibility determination process.

(b) A State may establish reasonable eligibility verification mechanisms to promote enrollment of eligible children and may permit applicants and enrollees to demonstrate that they meet eligibility requirements through self-declaration or affirmation except that a State may permit self-declaration of citizenship only if the State has effective, fair and non-discriminatory procedures to ensure the integrity of the application process in accordance with § 457.320(c).

Subpart D—State Plan Requirements: Coverage and Benefits

§ 457.401 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2102(a)(7) of the Act, which requires that States make assurances relating to, the quality and appropriateness of care, and access to covered services;

(2) Section 2103 of the Act, which outlines coverage requirements for children's health insurance;

(3) Section 2109 of the Act, which describes the relation of the SCHIP program to other laws;

(4) Section 2110(a) of the Act, which describes child health assistance; and

(5) Section 2110(c) of the Act, which contains definitions applicable to this subpart.

(b) *Scope.* This subpart sets forth requirements for health benefits coverage and child health assistance under a separate child health plan.

(c) *Applicability.* The requirements of this subpart apply to child health assistance provided under a separate child health program and do not apply to a Medicaid expansion program.

§ 457.402 Definition of child health assistance.

For the purpose of this subpart, the term ''child health assistance'' means payment for part or all of the cost of health benefits coverage provided to targeted low-income children for the following services:

(a) Inpatient hospital services.

(b) Outpatient hospital services.

(c) Physician services.

(d) Surgical services.

(e) Clinic services (including health center services) and other ambulatory health care services.

(f) Prescription drugs and biologicals and the administration of these drugs and biologicals, only if these drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(g) Over-the-counter medications.

(h) Laboratory and radiological services.

(i) Prenatal care and pre-pregnancy family planning services and supplies.

(j) Inpatient mental health services, other than services described in paragraph (r) of this section but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(k) Outpatient mental health services, other than services described in paragraph (s) of this section but including services furnished in a State-operated mental hospital and including community-based services.

(l) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices and adaptive devices).

(m) Disposable medical supplies.

(n) Home and community-based health care services and related supportive services (such as home health nursing services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members and minor modification to the home.)

(o) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing, pediatric nurse services and respiratory care services) in a home, school, or other setting.

(p) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of rape or incest.

(q) Dental services.

(r) Inpatient substance abuse treatment services and residential substance abuse treatment services.

(s) Outpatient substance abuse treatment services.

(t) Case management services.

(u) Care coordination services.

(v) Physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders.

(w) Hospice care.

(x) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

(1) Prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law;

(2) Performed under the general supervision or at the direction of a physician; or

(3) Furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

(y) Premiums for private health care insurance coverage.

(z) Medical transportation.

(aa) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

(bb) Any other health care services or items specified by the Secretary and not excluded under this subchapter.

§ 457.410 Health benefits coverage options.

(a) *Types of health benefits coverage.* States may choose to obtain any of the following four types of health benefits coverage:

(1) Benchmark coverage in accordance with § 457.420.

(2) Benchmark-equivalent coverage in accordance with § 457.430.

(3) Existing comprehensive State-based coverage in accordance with § 457.440.

(4) Secretary-approved coverage in accordance with § 457.450.

(b) *Required coverage.* Regardless of the type of health benefits coverage, described at paragraph (a) of this section, that the State chooses to obtain, the State must obtain coverage for—

(1) Well-baby and well-child care services as defined by the State;

(2) Age-appropriate immunizations in accordance with the recommendations of the Advisory Committee on Immunization Practices (ACIP); and

(3) Emergency services as defined in § 457.10.

§ 457.420 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is substantially equal to the health benefits coverage in one of the following benefit plans:

(a) *Federal Employees Health Benefit Plan (FEHBP).* The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under, 5 U.S.C. 8903(1).

(b) *State employee plan.* A health benefits plan that is offered and generally available to State employees in the State.

(c) *Health maintenance organization (HMO) plan.* A health insurance coverage plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, non-Medicaid enrollment in the State.

§ 457.430 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value determined in accordance with § 457.431 that is at least actuarially equivalent to the coverage under one of the benchmark packages specified in § 457.420.

(b) *Required coverage.* In addition to the coverage required under § 457.410(b), benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(c) *Additional coverage.* (1) In addition to the categories of services in paragraph (b) of this section, benchmark-equivalent coverage may include coverage for any additional services specified in § 457.402.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent coverage package includes coverage for prescription drugs, mental health services, vision services or hearing services, then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the value of the coverage for such a category or service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§ 457.431 Actuarial report for benchmark-equivalent coverage.

(a) To obtain approval for benchmark-equivalent health benefits coverage described under § 457.430, the State must submit to HCFA an actuarial report that contains an actuarial opinion that the health benefits coverage meets the actuarial requirements under § 457.430. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared—

(1) By an individual who is a member of the American Academy of Actuaries;

(2) Using generally accepted actuarial principles and methodologies of the American Academy of Actuaries;

(3) Using a standardized set of utilization and price factors;

(4) Using a standardized population that is representative of privately insured children of the age of those expected to be covered under the State plan;

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services);

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

(7) Taking into account the ability of a State to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by HCFA, to replicate the State's result.

§ 457.440 Existing comprehensive State-based coverage.

(a) *General requirements.* Existing comprehensive State-based health benefits is coverage that—

(1) Includes coverage of a range of benefits;

(2) Is administered or overseen by the State and receives funds from the State;

(3) Is offered in the State of New York, Florida or Pennsylvania; and

(4) Was offered as of August 5, 1997.

(b) *Modifications.* A State may modify an existing comprehensive State-based coverage program described in paragraph (a) of this section if—

(1) The program continues to include a range of benefits;

(2) The State submits an actuarial report demonstrating that the modification does not reduce the

actuarial value of the coverage under the program below the lower of either—

(i) The actuarial value of the coverage under the program as of August 5, 1997; or

(ii) The actuarial value of a benchmark benefit package as described in § 457.430 evaluated at the time the modification is requested.

§ 457.450 Secretary-approved coverage.

Secretary-approved coverage is health benefits coverage that, in the determination of the Secretary, provides appropriate coverage for the population of targeted low-income children covered under the program. Secretary-approved coverage, for which no actuarial analysis is required, may include—

(a) Coverage that is the same as the coverage provided to children under the Medicaid State plan;

(b) Comprehensive coverage offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act that either includes coverage for the full Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or that the State has extended to the entire Medicaid population in the State;

(c) Coverage that includes benchmark health benefits coverage, as specified in § 457.420, plus any additional coverage; or

(d) Coverage, including coverage under a group health plan purchased by the State, that the State demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan, as specified in § 457.420, through use of a benefit-by-benefit comparison of the coverage demonstrating that coverage for each benefit meets or exceeds the corresponding coverage under the benchmark health benefits plan.

§ 457.470 Prohibited coverage.

A State is not required to provide health benefits coverage under the plan for an item or service for which payment is prohibited under title XXI even if any benchmark health benefits plan includes coverage for that item or service.

§ 457.475 Limitations on coverage: Abortions.

(a) *General rule.* FFP under title XXI is not available in expenditures for an abortion, or in expenditures for the purchase of health benefits coverage that includes coverage of abortion services unless the abortion services meet the conditions specified in paragraph (b) of this section.

(b) *Exceptions.* (1) *Life of mother.* FFP is available in expenditures for abortion services when a physician has found that the abortion is necessary to save the life of the mother.

(2) *Rape or incest.* FFP is available in expenditures for abortion services performed to terminate a pregnancy resulting from an act of rape or incest.

(c) *Partial Federal funding prohibited.* (1) FFP is not available to a State for any amount expended under the title XXI plan to assist in the purchase, in whole or in part, of health benefits coverage that includes coverage of abortions other than those specified in paragraph (b) of this section.

(2) If a State wishes to have managed care entities provide abortions in addition to those specified in paragraph (b) of this section, those abortions must be provided under a separate contract using non-Federal funds. A State may not set aside a portion of the capitated rate paid to a managed care entity to be paid with State-only funds, or append riders, attachments or addenda to existing contracts with managed care entities to separate the additional abortion services from the other services covered by the contract.

(3) Nothing in this section affects the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than those expended under the State plan) for any abortion services or for health benefits coverage that includes coverage of abortion services.

§ 457.480 Preexisting condition exclusions and relation to other laws.

(a) *Preexisting condition exclusions.* (1) Except as permitted under paragraph (a)(2) of this section, the State may not permit the imposition of any pre-existing condition exclusion for covered services under the State plan.

(2) If the State obtains health benefits coverage through payment or a contract for health benefits coverage under a group health plan or group health insurance coverage, the State may permit the imposition of a pre-existing condition exclusion but only to the extent that the exclusion is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA) and title XXVII of the Public Health Service Act.

(b) *Relation of title XXI to other laws.* (1) ERISA. Nothing in this title affects or modifies section 514 of ERISA with respect to a group health plan as defined by section 2791(a)(1) of the Public Health Service Act.

(2) *Health Insurance Portability and Accountability Act (HIPAA).* Health benefits coverage provided under a State plan and coverage provided as a cost-effective alternative, as described in subpart J of this part, is creditable coverage for purposes of part 7 of subtitle B of title II of ERISA, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

(3) *Mental Health Parity Act (MHPA).* Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the MHPA of 1996 regarding parity in the application of annual and lifetime dollar limits to mental health benefits in accordance with 45 CFR 146.136.

(4) *Newborns and Mothers Health Protection Act (NMHPA).* Health benefits coverage under a group health plan provided under a State plan must comply with the requirements of the NMHPA of 1996 regarding requirements for minimum hospital stays for mothers and newborns in accordance with 45 CFR 146.130 and 148.170.

§ 457.490 Delivery and utilization control systems.

A State that elects to obtain health benefits coverage through a separate child health program must include in its State plan a description of the child health assistance provided under the plan for targeted low-income children, including a description of the proposed methods of delivery and utilization control systems. A State must—

(a) Describe the methods of delivery of child health assistance including the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations; and

(b) Describe utilization control systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan.

§ 457.495 State assurance of access to care and procedures to assure quality and appropriateness of care.

A State plan must include a description of the methods that a State uses for assuring the quality and appropriateness of care provided under the plan, including how the State will assure:

(a) Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations.

(b) Access to covered services, including emergency services as defined at § 457.10.

(c) Appropriate and timely procedures to monitor and treat enrollees with

chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

(d) That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services. A possible extension of up to 14 days may be permitted if the enrollee requests the extension or if the physician or health plan determines that additional information is needed.

Subpart E—State Plan Requirements: Enrollee Financial Responsibilities

§ 457.500 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements—

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2103(e) of the Act, which sets forth provisions regarding State plan requirements and options for cost sharing.

(b) *Scope.* This subpart consists of provisions relating to the imposition under a separate child health program of cost-sharing charges including enrollment fees, premiums, deductibles, coinsurance, copayments, and similar cost-sharing charges.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.505 General State plan requirements.

The State plan must include a description of—

(a) The amount of premiums, deductibles, coinsurance, copayments, and other cost sharing imposed;

(b) The methods, including the public schedule, the State uses to inform enrollees, applicants, providers and the general public of the cost-sharing charges, the cumulative cost-sharing maximum, and any changes to these amounts;

(c) The disenrollment protections as required under § 457.570;

(d) In the case of coverage obtained through premium assistance for group health plans—

(1) The procedures the State uses to ensure that enrollees are not charged copayments, coinsurance, deductibles or similar fees on well-baby and well-child care services described at § 457.520, and that any cost sharing complies with the requirements of this subpart;

(2) The procedures to ensure that American Indian and Alaska Native children are not charged premiums, copayments, coinsurance, deductibles, or similar fees in accordance with § 457.535;

(3) The procedures to ensure that enrollees are not charged cost sharing in excess of the cumulative cost-sharing maximum specified in § 457.560.

(e) Procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee to ensure compliance with this subpart.

§ 457.510 Premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes premiums, enrollment fees, or similar fees on enrollees, the State plan must describe—

(a) The amount of the premium, enrollment fee or similar fee imposed on enrollees;

(b) The time period for which the charge is imposed;

(c) The group or groups that are subject to the premiums, enrollment fees, or similar charges;

(d) The consequences for an enrollee or applicant who does not pay a charge, and the disenrollment protections adopted by the State in accordance with § 457.570; and

(e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in § 457.560.

§ 457.515 Co-payments, coinsurance, deductibles, or similar cost-sharing charges: State plan requirements.

To impose copayments, coinsurance, deductibles or similar charges on enrollees, the State plan must describe—

(a) The service for which the charge is imposed;

(b) The amount of the charge;

(c) The group or groups of enrollees that may be subject to the cost-sharing charge;

(d) The consequences for an enrollee who does not pay a charge, and the disenrollment protections adopted by the State in accordance with § 457.570;

(e) The methodology used to ensure that total cost-sharing liability for a family does not exceed the cumulative cost-sharing maximum specified in § 457.560; and

(f) An assurance that enrollees will not be held liable for cost-sharing amounts for emergency services that are provided at a facility that does not participate in the enrollee's managed care network beyond the copayment amounts specified in the State plan for emergency services as defined in § 457.10.

§ 457.520 Cost sharing for well-baby and well-child care services.

(a) A State may not impose copayments, deductibles, coinsurance or other cost sharing with respect to the well-baby and well-child care services covered under the State plan in either the managed care delivery setting or the fee-for-service delivery setting.

(b) For the purposes of this subpart, at a minimum, any of the following services covered under the State plan will be considered well-baby and well-child care services:

(1) All healthy newborn physician visits, including routine screening, whether provided on an inpatient or outpatient basis.

(2) Routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) ''Guidelines for Health Supervision III'' and described in ''Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.''

(3) Laboratory tests associated with the well-baby and well-child routine physical examinations as described in paragraph (b)(2) of this section.

(4) Immunizations and related office visits as recommended and updated by the Advisory Committee on Immunization Practices (ACIP).

(5) Routine preventive and diagnostic dental services (such as oral examinations, prophylaxis and topical fluoride applications, sealants, and x-rays) as described in the most recent guidelines issued by the American Academy of Pediatric Dentistry (AAPD).

§ 457.525 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current cost-sharing charges.

(2) Enrollee groups subject to the charges.

(3) Cumulative cost-sharing maximums.

(4) Mechanisms for making payments for required charges.

(5) The consequences for an applicant or an enrollee who does not pay a charge, including the disenrollment protections required by § 457.570.

(b) The State must make the public schedule available to the following groups:

(1) Enrollees, at the time of enrollment and reenrollment after a

redetermination of eligibility, and when cost-sharing charges and cumulative cost-sharing maximums are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

§ 457.530 General cost-sharing protection for lower income children.

The State may vary premiums, deductibles, coinsurance, copayments or any other cost sharing based on family income only in a manner that does not favor children from families with higher income over children from families with lower income.

§ 457.535 Cost-sharing protection to ensure enrollment of American Indians and Alaska Natives.

States may not impose premiums, deductibles, coinsurance, copayments or any other cost-sharing charges on children who are American Indians or Alaska Natives, as defined in § 457.10.

§ 457.540 Cost-sharing charges for children in families with incomes at or below 150 percent of the FPL.

The State may impose premiums, enrollment fees, deductibles, copayments, coinsurance, cost sharing and other similar charges for children whose family income is at or below 150 percent of the FPL as long as—

(a) Aggregate monthly enrollment fees, premiums, or similar charges imposed on a family are less than or equal to the maximum amounts permitted under § 447.52 of this chapter for a Medicaid eligible family of the same size and income;

(b) Any copayments, coinsurance, deductibles or similar charges for children whose family income is at or below 100 percent of the FPL are equal to or less than the amounts permitted under § 447.54 of this chapter;

(c) For children whose family income is from 101 percent to 150 percent of the FPL, any copayments, coinsurance, deductibles or similar charges are equal to or less than the maximum amounts permitted under § 457.555;

(d) The State does not impose more than one type of cost-sharing charge (deductible, copayment, or coinsurance) on a service;

(e) The State only imposes one copayment based on the total cost of services furnished during one office visit; and

(f) Aggregate annual cost sharing of all types, with respect to all targeted low-income children in a family, does not exceed the maximum permitted under § 457.560(b).

§ 457.555 Maximum allowable cost-sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) *Non-institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services—

(1) Any copayment or similar charge the State imposes under a fee-for-service delivery system does not exceed the following amounts:

Total cost of services provided during a visit	Maximum amount chargeable to enrollee
$15.00 or less	$1.00
$15.01 to $40	2.00
$40.01 to $80	3.00
$80.01 or more	5.00

(2) Any copayment that the State imposes for services provided by a managed care organization may not exceed $5.00 per visit;

(3) Any coinsurance rate the State imposes may not exceed 5 percent of the payment the State directly or through contract makes for the service; and

(4) Any deductible the State imposes may not exceed $3.00 per month, per family for each period of eligibility.

(b) *Institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the maximum deductible, coinsurance or copayment charge for each institutional admission may not exceed 50 percent of the payment the State would make under the Medicaid fee-for-service system for the first day of care in the institution.

(c) *Institutional emergency services.* Any copayment that the State imposes on emergency services provided by an institution may not exceed $5.00.

(d) *Nonemergency use of the emergency room.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of $10.00, for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10.

(e) *Standard copayment amount.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, a standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in paragraphs (a), (b), and (c) of this section to the State's average or typical payment for that service.

§ 457.560 Cumulative cost-sharing maximum.

(a) *Computation.* A State must count cost-sharing amounts that the family has a legal obligation to pay in computing whether a family has met the cumulative cost-sharing maximum. A family will be considered to have a legal obligation to pay amounts a provider actually charges the family for covered services furnished to enrollees, and any other amounts for which payment is required under applicable State law for covered services furnished to eligible children, even if the family never pays those amounts.

(b) *Children with family incomes at or below 150 percent of the FPL.* For targeted low-income children with family income at or below 150 percent of the FPL, the State may not impose premiums, deductibles, copayments, coinsurance, enrollment fees, or similar cost-sharing charges that, in the aggregate, exceed 2.5 percent of total family income for the length of the child's eligibility period in the State.

(c) *Children with family incomes above 150 percent of the FPL.* For targeted low-income children with family income above 150 percent of the FPL, the State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of total family income for the length of the child's eligibility period in the State.

(d) The State must inform the enrollee's family in writing and orally if appropriate of their individual cumulative cost-sharing maximum amount at the time of enrollment and reenrollment.

§ 457.570 Disenrollment protections.

(a) The State must give enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

(b) The disenrollment process must afford the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges, and in the event that such a showing indicates that the enrollee may have become eligible for Medicaid or for a lower level of cost sharing, the State must facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate.

(c) The State must provide the enrollee with an opportunity for an impartial review to address

disenrollment from the program in accordance with § 457.1130(a)(3).

Subpart F—Payments to States

§ 457.624 [Removed]

8. Section 457.624 is removed.

9. New subparts G, H, I, J, and K are added to read as follows:

Subpart G—Strategic Planning, Reporting, and Evaluation

Sec.
457.700 Basis, scope, and applicability.
457.710 State plan requirements: Strategic objectives and performance goals.
457.720 State plan requirement: State assurance regarding data collection, records, and reports.
457.740 State expenditures and statistical reports.
457.750 Annual report.

Subpart H—Substitution of Coverage

457.800 Basis, scope, and applicability.
457.805 State plan requirements: Procedures to address substitution under group health plans.
457.810 Premium assistance programs: Required protections against substitution.

Subpart I—Program Integrity

457.900 Basis, scope, and applicability.
457.902 Definitions.
457.910 State program administration.
457.915 Fraud detection and investigation.
457.925 Preliminary investigation.
457.930 Full investigation, resolution, and reporting requirements.
457.935 Sanctions and related penalties.
457.940 Procurement standards.
457.945 Certification for contracts and proposals.
457.950 Contract and payment requirements including certification of payment-related information.
457.955 Conditions necessary to contract as a managed care entity (MCE).
457.960 Reporting changes in eligibility and redetermining eligibility.
457.965 Documentation.
457.980 Verification of enrollment and provider services received.
457.985 Integrity of professional advice to enrollees.

Subpart J—Allowable Waivers: General Provisions

457.1000 Basis, scope, and applicability.
457.1003 HCFA review of waiver requests.
457.1005 Waiver for cost-effective coverage through a community-based health delivery system.
457.1010 Waiver for purchase of family coverage.
457.1015 Cost-effectiveness.

Subpart K—State Plan Requirements: Applicant and Enrollee Protections

457.1100 Basis, scope and applicability.
457.1110 Privacy protections.
457.1120 State plan requirement: Description of review process.
457.1130 Matters subject to review.
457.1140 Core elements of review.
457.1150 Impartial review.
457.1160 Time frames.
457.1170 Continuation of enrollment.
457.1180 Notice.
457.1190 Application of review procedures when States offer premium assistance for group health plans.

Subpart G—Strategic Planning, Reporting, and Evaluation

§ 457.700 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart implements—

(1) Sections 2107(a), (b) and (d) of the Act, which set forth requirements for strategic planning, reports, and program budgets; and

(2) Section 2108 of the Act, which sets forth provisions regarding annual reports and evaluation.

(b) *Scope.* This subpart sets forth requirements for strategic planning, monitoring, reporting and evaluation under title XXI.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs and Medicaid expansion programs.

§ 457.710 State plan requirements: Strategic objectives and performance goals.

(a) *Plan description.* A State plan must include a description of—

(1) The strategic objectives as described in paragraph (b) of this section;

(2) The performance goals as described in paragraph (c) of this section; and

(3) The performance measurements, as described in paragraph (d) of this section, that the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

(b) *Strategic objectives.* The State plan must identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

(c) *Performance goals.* The State plan must specify one or more performance goals for each strategic objective identified.

(d) *Performance measurements.* The State plan must describe how performance under the plan is—

(1) Measured through objective, independently verifiable means; and

(2) Compared against performance goals.

(e) *Core elements.* The State's strategic objectives, performance goals and performance measures must include a common core of national performance goals and measures consistent with the data collection, standard methodology, and verification requirements, as developed by the Secretary.

§ 457.720 State plan requirement: State assurance regarding data collection, records, and reports.

A State plan must include an assurance that the State collects data, maintains records, and furnishes reports to the Secretary, at the times and in the standardized format the Secretary may require to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under title XXI.

§ 457.740 State expenditures and statistical reports.

(a) *Required quarterly reports.* A State must submit reports to HCFA that contain quarterly program expenditures and statistical data no later than 30 days after the end of each quarter of the Federal fiscal year. A State must collect required data beginning on the date of implementation of the approved State plan. Territories are exempt from the definition of ''State'' for purposes of the required quarterly reporting under this section. The quarterly reports must include data on—

(1) Program expenditures;

(2) The number of children enrolled in the title XIX Medicaid program, the separate child health program, and the Medicaid expansion program, as applicable, as of the last day of each quarter of the Federal fiscal year; and

(3) The number of children under 19 years of age who are enrolled in the title XIX Medicaid program, the separate child health program, and in the Medicaid expansion program, as appropriate, by the following categories:

(i) Age (under 1 year of age, 1 through 5 years of age, 6 through 12 years of age, and 13 through 18 years of age).

(ii) Gender, race, and ethnicity.

(iii) Service delivery system (managed care, fee-for-service, and primary care case management).

(iv) Family income as a percentage of the Federal poverty level as described in paragraph (b) of this section.

(b) *Reportable family income categories.* (1) A State that does not impose cost sharing or a State that imposes cost sharing based on a fixed percentage of income must report by two family income categories:

(i) At or below 150 percent of FPL.

(ii) Over 150 percent of FPL.

(2) A State that imposes a different level or percentage of cost sharing at different poverty levels must report by poverty level categories that match the

poverty level categories used for purposes of cost sharing.

(c) *Required unduplicated counts.* Thirty days after the end of the Federal fiscal year, the State must submit an unduplicated count for the Federal fiscal year of children who were enrolled in the Medicaid program, the separate child health program, and the Medicaid expansion program, as appropriate, by age, gender, race, ethnicity, service delivery system, and poverty level categories described in paragraphs (a) and (b) of this section.

§ 457.750 Annual report.

(a) *Report required for each Federal fiscal year.* A State must report to HCFA by January 1 following the end of each Federal fiscal year, on the results of the State's assessment of the operation of the State plan.

(b) *Contents of annual report.* In the annual report required under paragraph (a) of this section, a State must—

(1) Describe the State's progress in reducing the number of uncovered, low-income children and; in meeting other strategic objectives and performance goals identified in the State plan; and provide information related to a core set of national performance goals and measures as developed by the Secretary;

(2) Report on the effectiveness of the State's policies for discouraging the substitution of public coverage for private coverage;

(3) Identify successes and barriers in State plan design and implementation, and the approaches the State is considering to overcome these barriers;

(4) Describe the State's progress in addressing any specific issues (such as outreach) that the State plan proposed to periodically monitor and assess;

(5) Provide an updated budget for a 3-year period that describes those elements required in § 457.140, including any changes in the sources of the non-Federal share of State plan expenditures;

(6) Identify the total State expenditures for family coverage and total number of children and adults, respectively, covered by family coverage during the preceding Federal fiscal year;

(7) Collect and provide data regarding the primary language of SCHIP enrollees; and

(8) Describe the State's current income standards and methodologies for its Medicaid expansion program, separate child health program, and title XIX Medicaid program, as appropriate.

(c) *Methodology for estimate of number of uninsured, low-income children.* (1) To report on the progress made in reducing the number of uninsured, low-income children as required in paragraph (b) of this section, a State must choose a methodology to establish an initial baseline estimate of the number of low-income children who are uninsured in the State.

(i) A State may base the estimate on data from—

(A) The March supplement to the Current Population Survey (CPS);

(B) A State-specific survey;

(C) A statistically adjusted CPS; or

(D) Another appropriate source.

(ii) If the State does not base the estimate on data from the March supplement to the CPS, the State must submit a description of the methodology used to develop the initial baseline estimate and the rationale for its use.

(2) The State must provide an annual estimate of changes in the number of uninsured in the State using—

(i) The same methodology used in establishing the initial baseline; or

(ii) Another methodology based on new information that enables the State to establish a new baseline.

(3) If a new methodology is used, the State must also provide annual estimates based on either the March supplement to the CPS or the methodology used to develop the initial baseline.

Subpart H—Substitution of Coverage

§ 457.800 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements section 2102(b)(3)(C) of the Act, which provides that the State plan must include a description of procedures the State uses to ensure that health benefits coverage provided under the State plan does not substitute for coverage under group health plans.

(b) *Scope.* This subpart sets forth State plan requirements relating to substitution of coverage in general and specific requirements relating to substitution of coverage under premium assistance programs.

(c) *Applicability.* The requirements of this subpart apply to separate child health programs.

§ 457.805 State plan requirement: Procedures to address substitution under group health plans.

The State plan must include a description of reasonable procedures to ensure that health benefits coverage provided under the State plan does not substitute for coverage provided under group health plans as defined at § 457.10.

§ 457.810 Premium assistance programs: Required protections against substitution.

A State that operates a premium assistance program, as defined at § 457.10, must provide the protections against substitution of SCHIP coverage for coverage under group health plans specified in this section. The State must describe these protections in the State plan; and report on results of monitoring of substitution in its annual reports.

(a) *Minimum period without coverage under a group health plan.* For health benefits coverage provided through premium assistance for group health plans, the following rules apply:

(1) An enrollee must not have had coverage under a group health plan for a period of at least 6 months prior to enrollment in a premium assistance program. A State may not require a minimum period without coverage under a group health plan that exceeds 12 months.

(2) States may permit reasonable exceptions to the requirement for a minimum period without coverage under a group health plan for—

(i) Involuntary loss of coverage under a group health plan, due to employer termination of coverage for all employees and dependents;

(ii) Economic hardship;

(iii) Change to employment that does not offer dependent coverage; or

(iv) Other reasons proposed by the State and approved as part of the State plan.

(3) The requirement for a minimum period without coverage under a group health plan does not apply to a child who, within the previous 6 months, has received coverage under a group health plan through Medicaid under section 1906 of the Act.

(4) The Secretary may waive the 6-month waiting period requirement described in this section at her discretion.

(b) *Employer contribution.* For health benefits coverage obtained through premium assistance for group health plans, the employee who is eligible for the coverage must apply for the full premium contribution available from the employer.

(c) *Cost effectiveness.* In establishing cost effectiveness—

(1) The State's cost for coverage for children under premium assistance programs must not be greater than the cost of other SCHIP coverage for these children; and

(2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage for children under premium assistance programs to the cost of other SCHIP coverage for these children, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

(d) *State evaluation.* The State must evaluate and report in the annual report (in accordance with § 457.750(b)(2)) the amount of substitution that occurs as a result of premium assistance programs and the effect of those programs on access to coverage.

Subpart I—Program Integrity

§ 457.900 Basis, scope and applicability.

(a) *Statutory basis.* This subpart implements—

(1) Section 2101(a) of the Act, which provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner; and

(2) Section 2107(e) of the Act, which provides that certain title XIX and title XI provisions, including the following, apply to States under title XXI in the same manner as they apply to a State under title XIX:

(i) Section 1902(a)(4)(C) of the Act, relating to conflict of interest standards.

(ii) Paragraphs (2), (16), and (17), of section 1903(i) of the Act, relating to limitations on payment.

(iii) Section 1903(w) of the Act, relating to limitations on provider taxes and donations.

(iv) Section 1124 of the Act, relating to disclosure of ownership and related information.

(v) Section 1126 of the Act, relating to disclosure of information about certain convicted individuals.

(vi) Section 1128 of the Act, relating to exclusions.

(vii) Section 1128A of the Act, relating to civil monetary penalties.

(viii) Section 1128B(d) of the Act, relating to criminal penalties for certain additional charges.

(ix) Section 1132 of the Act, relating to periods within which claims must be filed.

(b) *Scope.* This subpart sets forth requirements, options, and standards for program integrity assurances that must be included in the approved State plan.

(c) *Applicability.* This subpart applies to separate child health programs. Medicaid expansion programs are subject to the program integrity rules and requirements specified under title XIX.

§ 457.902 Definitions

As used in this subpart—

Actuarially sound principles means generally accepted actuarial principles and practices that are applied to determine aggregate utilization patterns, are appropriate for the population and services to be covered, and have been certified by actuaries who meet the qualification standards established by the Actuarial Standards Board.

Fee-for-service entity means any individual or entity that furnishes services under the program on a fee-for-service basis, including health insurance services.

§ 457.910 State program administration.

The State's child health program must include—

(a) Methods of administration that the Secretary finds necessary for the proper and efficient operation of the separate child health program; and

(b) Safeguards necessary to ensure that—

(1) Eligibility will be determined appropriately in accordance with subpart C of this part; and

(2) Services will be provided in a manner consistent with administrative simplification and with the provisions of subpart D of this part.

§ 457.915 Fraud detection and investigation.

(a) *State program requirements.* The State must establish procedures for ensuring program integrity and detecting fraudulent or abusive activity. These procedures must include the following:

(1) Methods and criteria for identifying suspected fraud and abuse cases.

(2) Methods for investigating fraud and abuse cases that—

(i) Do not infringe on legal rights of persons involved; and

(ii) Afford due process of law.

(b) *State program integrity unit.* The State may establish an administrative agency responsible for monitoring and maintaining the integrity of the separate child health program.

(c) *Program coordination.* The State must develop and implement procedures for referring suspected fraud and abuse cases to the State program integrity unit (if such a unit is established) and to appropriate law enforcement officials. Law enforcement officials include the—

(1) U.S. Department of Health and Human Services Office of Inspector General (OIG);

(2) U.S. Attorney's Office, Department of Justice (DOJ);

(3) Federal Bureau of Investigation (FBI); and

(4) State Attorney General's office.

§ 457.925 Preliminary investigation.

If the State agency receives a complaint of fraud or abuse from any source or identifies questionable practices, the State agency must conduct a preliminary investigation or take otherwise appropriate action within a reasonable period of time to determine whether there is sufficient basis to warrant a full investigation.

§ 457.930 Full investigation, resolution, and reporting requirements.

The State must establish and implement effective procedures for investigating and resolving suspected and apparent instances of fraud and abuse. Once the State determines that a full investigation is warranted, the State must implement procedures including, but not limited to the following:

(a) Cooperate with and refer potential fraud and abuse cases to the State program integrity unit, if such a unit exists.

(b) Conduct a full investigation.

(c) Refer the fraud and abuse case to appropriate law enforcement officials.

§ 457.935 Sanctions and related penalties.

(a) A State may not make payments for any item or service furnished, ordered, or prescribed under a separate child health program to any provider who has been excluded from participating in the Medicare and Medicaid programs.

(b) The following provisions and their corresponding regulations apply to a State under title XXI, in the same manner as these provisions and regulations apply to a State under title XIX:

(1) Part 455, subpart B of this chapter.

(2) Section 1124 of the Act pertaining to disclosure of ownership and related information.

(3) Section 1126 of the Act pertaining to disclosure by institutions, organizations, and agencies of owners and certain other individuals who have been convicted of certain offenses.

(4) Section 1128 of the Act pertaining to exclusions.

(5) Section 1128A of the Act pertaining to civil monetary penalties.

(6) Section 1128B of the Act pertaining to criminal penalties for acts involving Federal health care programs.

(7) Section 1128E of the Act pertaining to the reporting of final adverse actions on liability findings made against health care providers, suppliers, and practitioners under the health care fraud and abuse data collection program.

§ 457.940 Procurement standards.

(a) A State must submit to HCFA a written assurance that title XXI services will be provided in an effective and efficient manner. The State must submit the assurance—

(1) With the initial State plan; or

(2) For States with approved plans, with the first request to amend the approved plan.

(b) A State must—

(1) Provide for free and open competition, to the maximum extent practical, in the bidding of all procurement contracts for coverage or other services in accordance with the procurement requirements of 45 CFR 74.43; or

(2) Use payment rates based on public or private payment rates for comparable services for comparable populations, consistent with principles of actuarial soundness as defined at § 457.902.

(c) A State may establish higher rates than permitted under paragraph (b) of this section if such rates are necessary to ensure sufficient provider participation, provider access, or to enroll providers who demonstrate exceptional efficiency or quality in the provision of services.

(d) All contracts under this part must include provisions that define a sound and complete procurement contract, as required by 45 CFR part 74.

(e) The State must provide to HCFA, if requested, a description of the manner in which rates were developed in accordance with the requirements of paragraphs (b) or (c) of this section.

§ 457.945 Certification for contracts and proposals.

Entities that contract with the State under a separate child health program must certify the accuracy, completeness, and truthfulness of information in contracts and proposals, including information on subcontractors, and other related documents, as specified by the State.

§ 457.950 Contract and payment requirements including certification of payment-related information.

(a) *Managed care entity (MCE).* A State that makes payments to an MCE under a separate child health program, based on data submitted by the MCE, must ensure that its contract requires the MCE to provide—

(1) Enrollment information and other information required by the State;

(2) An attestation to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury;

(3) Access for the State, HCFA, and the HHS Office of the Inspector General to enrollee health claims data and payment data, in conformance with the appropriate privacy protections in the State; and

(4) A guarantee that the MCE will not avoid costs for services covered in its contract by referring enrollees to publicly supported health care resources.

(b) *Fee-for-service entities.* A State that makes payments to fee-for-service entities under a separate child health program must—

(1) Establish procedures to ensure that the entity certifies and attests that information on claim forms is truthful, accurate, and complete;

(2) Ensure that fee-for-service entities understand that payment and satisfaction of the claims will be from Federal and State funds, and that any false claims may be prosecuted under applicable Federal or State laws; and

(3) Require, as a condition of participation, that fee-for-service entities provide the State, HCFA and/or the HHS Office of the Inspector General with access to enrollee health claims data, claims payment data and related records.

§ 457.955 Conditions necessary to contract as a managed care entity (MCE).

(a) The State must assure that any entity seeking to contract as an MCE under a separate child health program has administrative and management arrangements or procedures designed to safeguard against fraud and abuse.

(b) The State must ensure that the arrangements or procedures required in paragraph (a) of this section—

(1) Enforce MCE compliance with all applicable Federal and State standards;

(2) Prohibit MCEs from conducting any unsolicited personal contact with a potential enrollee by an employee or agent of a managed care entity for the purpose of influencing the individual to enroll with the entity; and

(3) Include a mechanism for the MCE to report to the State, to HCFA, or to the Office of Inspector General (OIG) as appropriate, information on violations of law by subcontractors or enrollees of an MCE and other individuals.

(c) With respect to enrollees, the reporting requirement in paragraph (b)(3) of this section applies only to information on violations of law that pertain to enrollment in the plan, or the provision of, or payment for, health services.

(d) The State may inspect, evaluate, and audit MCEs at any time, as necessary, in instances where the State determines that there is a reasonable possibility of fraudulent and abusive activity.

§ 457.960 Reporting changes in eligibility and redetermining eligibility.

If the State requires reporting of changes in circumstances that may affect the enrollee's eligibility for child health assistance, the State must:

(a) Establish procedures to ensure that enrollees make timely and accurate reports of any such change; and

(b) Promptly redetermine eligibility when the State has information about these changes.

§ 457.965 Documentation.

The State must include in each applicant's record facts to support the State's determination of the applicant's eligibility for SCHIP.

§ 457.980 Verification of enrollment and provider services received.

(a) The State must establish methodologies to verify whether beneficiaries have received services for which providers have billed.

(b) The State must establish and maintain systems to identify, report, and verify the accuracy of claims for those enrolled children who meet requirements of section 2105(a) of the Act, where enhanced Federal medical assistance percentage computations apply.

§ 457.985 Integrity of professional advice to enrollees.

The State must ensure through its contracts for coverage and services that its contractors comply with—

(a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and

(b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

Subpart J—Allowable Waivers: General Provisions

§ 457.1000 Basis, scope, and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2105(c)(2)(B) of the Act, which sets forth the requirements for a waiver to permit a State to exceed the 10 percent cost limit on expenditures other than benefit expenditures; and

(2) Section 2105(c)(3) of the Act, which permits a waiver for the purchase of family coverage.

(b) *Scope.* This subpart sets forth requirements for obtaining a waiver under title XXI.

(c) *Applicability.* This subpart applies to separate child health programs; and applies to Medicaid expansion programs when the State claims administrative costs under title XXI and seeks a waiver of limitations on such claims for use of a community-based health delivery

system. This subpart does not apply to demonstrations requested under section 1115 of the Act.

§ 457.1003 HCFA review of waiver requests.

HCFA will review the waiver requests under this subpart using the same time frames used for State plan amendments, as specified in § 457.160.

§ 457.1005 Waiver for cost-effective coverage through a community-based health delivery system.

(a) *Availability of waiver.* The Secretary may waive the requirements of § 457.618 (the 10 percent limit on expenditures not used for health benefits coverage for targeted low-income children, that meets the requirements of § 457.410) in order to provide child health assistance to targeted low-income children under the State plan through a cost-effective, community-based health care delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or section 1923 of the Act.

(b) *Requirements for obtaining a waiver.* To obtain a waiver for cost-effective coverage through a community-based health delivery system, a State must demonstrate that—

(1) The coverage meets all of the requirements of this part, including subpart D and subpart E.

(2) The cost of such coverage, on an average per child basis, does not exceed the cost of coverage under the State plan.

(c) *Three-year approval period.* An approved waiver remains in effect for no more than 3 years.

(d) *Application of cost savings.* If the cost of coverage of a child under a community-based health delivery system is equal to or less than the cost of coverage of a child under the State plan, the State may use the difference in the cost of coverage for each child enrolled in a community-based health delivery system for—

(1) Other child health assistance, health services initiatives, or outreach; or

(2) Any reasonable costs necessary to administer the State's program.

§ 457.1010 Waiver for purchase of family coverage.

A State may purchase family coverage that includes coverage for targeted low-income children if the State establishes that—

(a) Purchase of family coverage is cost-effective under the standards described in § 457.1015;

(b) The State does not purchase the coverage if it would otherwise substitute for health insurance coverage that would be provided to targeted, low-income children but for the purchase of family coverage; and

(c) The coverage for the family otherwise meets the requirements of this part.

§ 457.1015 Cost-effectiveness.

(a) *Definition.* For purposes of this subpart, ''cost-effective'' means that the State's cost of purchasing family coverage that includes coverage for targeted low-income children is equal to or less than the State's cost of obtaining coverage under the State plan only for the eligible targeted low-income children involved.

(b) *Cost comparisons.* A State may demonstrate cost-effectiveness by comparing the cost of coverage for the family to the cost of coverage only for the targeted low-income children under the health benefits package offered by the State under the State plan for which the child is eligible.

(c) *Individual or aggregate basis.* (1) The State may base its demonstration of the cost-effectiveness of family coverage on an assessment of the cost of family coverage for individual families, done on a case-by-case basis, or on the cost of family coverage in the aggregate.

(2) The State must assess cost-effectiveness in its initial request for a waiver and then annually.

(3) For any State that chooses the aggregate cost method, if an annual assessment of the cost-effectiveness of family coverage in the aggregate reveals that it is not cost-effective, the State must assess cost-effectiveness on a case-by-case basis.

(d) *Reports on family coverage.* A State with a waiver under this section must include in its annual report pursuant to § 457.750, the cost of family coverage purchased under the waiver, and the number of children and adults, respectively, covered under family coverage pursuant to the waiver.

Subpart K—State Plan Requirements: Applicant and Enrollee Protections

§ 457.1100 Basis, scope and applicability.

(a) *Statutory basis.* This subpart interprets and implements—

(1) Section 2101(a) of the Act, which states that the purpose of title XXI of the Act is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner;

(2) Section 2102(a)(7)(B) of the Act, which requires that the State plan include a description of the methods used to assure access to covered services, including emergency services;

(3) Section 2102(b)(2) of the Act, which requires that the State plan include a description of methods of establishing and continuing eligibility and enrollment; and

(4) Section 2103 of the Act, which outlines coverage requirements for a State that provides child health assistance through a separate child health program.

(b) *Scope.* This subpart sets forth minimum standards for privacy protection and for procedures for review of matters relating to eligibility, enrollment, and health services.

(c) *Applicability.* This subpart only applies to a separate child health program.

§ 457.1110 Privacy protections.

The State must ensure that, for individual medical records and any other health and enrollment information maintained with respect to enrollees, that identifies particular enrollees (in any form), the State establishes and implements procedures to—

(a) Abide by all applicable Federal and State laws regarding confidentiality and disclosure, including those laws addressing the confidentiality of information about minors and the privacy of minors, and privacy of individually identifiable health information;

(b) Comply with subpart F of part 431 of this chapter;

(c) Maintain the records and information in a timely and accurate manner;

(d) Specify and make available to any enrollee requesting it—

(1) The purposes for which information is maintained or used; and

(2) To whom and for what purposes the information will be disclosed outside the State;

(e) Except as provided by Federal and State law, ensure that each enrollee may request and receive a copy of records and information pertaining to the enrollee in a timely manner and that an enrollee may request that such records or information be supplemented or corrected.

§ 457.1120 State plan requirement: Description of review process.

A State plan must include a description of the State's review process that meets the requirements of §§ 457.1130, 457.1140, 457.1150, 457.1160, 457.1170, 457.1180, and 457.1190.

§ 457.1130 Matters subject to review.

(a) *Eligibility or enrollment matter.* A State must ensure that an applicant or enrollee has an opportunity for review, consistent with §§ 457.1140 and 457.1150, of a—

(1) Denial of eligibility;

(2) Failure to make a timely determination of eligibility; and

(3) Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

(b) *Health services matter.* A State must ensure that an enrollee has an opportunity for external review of a—

(1) Delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services; and

(2) Failure to approve, furnish, or provide payment for health services in a timely manner.

(c) *Exception.* A State is not required to provide an opportunity for review of a matter described in paragraph (a) or (b) of this section if the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

§ 457.1140 Core elements of review.

In adopting the procedures for review of matters described in § 457.1130, a State must ensure that—

(a) Reviews are conducted by an impartial person or entity in accordance with § 457.1150;

(b) Review decisions are timely in accordance with § 457.1160;

(c) Review decisions are written; and

(d) Applicants and enrollees have an opportunity to—

(1) Represent themselves or have representatives of their choosing in the review process;

(2) Timely review their files and other applicable information relevant to the review of the decision;

(3) Fully participate in the review process, whether the review is conducted in person or in writing, including by presenting supplemental information during the review process; and

(4) Receive continued enrollment in accordance with § 457.1170.

§ 457.1150 Impartial review.

(a) *Eligibility or enrollment matter.* The review of a matter described in § 457.1130(a) must be conducted by a person or entity who has not been directly involved in the matter under review.

(b) *Health services matter.* The State must ensure that an enrollee has an opportunity for an independent external review of a matter described in § 457.1130(b). External review must be conducted by the State or a contractor other than the contractor responsible for the matter subject to external review.

§ 457.1160 Time frames.

(a) *Eligibility or enrollment matter.* A State must complete the review of a matter described in § 457.1130(a) within a reasonable amount of time. In setting time frames, the State must consider the need for expedited review when there is an immediate need for health services.

(b) *Health services matter.* The State must ensure that reviews are completed in accordance with the medical needs of the patient. If the medical needs of the patient do not dictate a shorter time frame, the review must be completed within the following time frames:

(1) *Standard timeframe.* A State must ensure that external review, as described in § 457.1150(b), is completed within 90 calendar days of the date an enrollee requests internal (if available) or external review. If both internal and external review are available to the enrollee, both types of review must be completed within the 90 calendar day period.

(2) *Expedited timeframe.* A State must ensure that external review, as described in § 457.1150(b), is completed within 72 hours of the time an enrollee requests external review, if the enrollee's physician or health plan determines that operating under the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. If the enrollee has access to internal and external review, then each level of review may take no more than 72 hours. The State may extend the 72-hour time frame by up to 14 calendar days, if the enrollee requests an extension.

§ 457.1170 Continuation of enrollment.

A State must ensure the opportunity for continuation of enrollment pending the completion of review of a suspension or termination of enrollment, including a decision to disenroll for failure to pay cost sharing.

§ 457.1180 Notice.

A State must provide enrollees and applicants timely written notice of any determinations required to be subject to review under § 457.1130 that includes the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

§ 457.1190 Application of review procedures when States offer premium assistance for group health plans.

A State that has a premium assistance program through which it provides coverage under a group health plan that does not meet the requirements of §§ 457.1130(b), 457.1140, 457.1150(b), 457.1160(b), and 457.1180 must give applicants and enrollees the option to obtain health benefits coverage other than through that group health plan. The State must provide this option at initial enrollment and at each redetermination of eligibility.

(Catalog of Federal Domestic Assistance Program No. 00.000, State Children's Health Insurance Program)

Dated: January 4, 2001.

Robert A. Berenson,

Acting Deputy Administrator, Health Care Financing Administration.

Dated: January 4, 2001.

Donna E. Shalala,

Secretary.

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Part III

Department of Labor

Employment and Training Administration

20 CFR Part 645
Welfare-to-Work (WtW) Grants; Final Rule; Interim Final Rule

DEPARTMENT OF LABOR

Employment and Training Administration

20 CFR Part 645

RIN 1205–AB15

Welfare-to-Work (WtW) Grants

AGENCY: Employment and Training Administration (ETA), DOL.

ACTION: Final Rule; Interim Final Rule, Request for comments.

SUMMARY: The Department of Labor (the Department) hereby issues a Final Rule implementing the Welfare-to-Work (WtW) grant provisions of Title IV, Part A of the Social Security Act. This action completes the rulemaking initiated by the publication of the Interim Final Rule (IFR1) on November 18, 1997. The Final Rule revises the IFR1 to reflect public comment, where appropriate. In addition, many matters of concern raised by commenters have been the subject of legislative changes to the WtW statute. Changes have been made to reflect new statutory requirements for these matters. Final Rule revisions to IFR1 are discussed in detail in Section II of this preamble.

In addition, the Department hereby issues a new Interim Final Rule (IFR2) implementing the Welfare-to-Work and Child Support Amendments of 1999 (1999 Amendments) which Congress passed on November 29, 1999 with the Administration's support. The 1999 Amendments, among other things, significantly changed the eligibility criteria for the Welfare-to-Work program. In IFR2, we have made the regulatory changes required by the 1999 Amendments. These changes are discussed in Section III of this preamble. The Department requests public comment only on these new provisions and changes.

So that all new changes to the WtW regulations are contained in one place, we are publishing the Final Rule and IFR2 in one package.

DATES: *Effective Dates:* These amendments will become effective on February 12, 2001.

Comment Date: We invite comments only on those changes that are the result of the 1999 Amendments, contained in IFR2. These changes are described in Section III of this preamble. All comments must be received by the Department on or before March 12, 2001.

ADDRESSES: Written comments on the changes to the regulations contained in IFR2 (described in Section III of this preamble) may be mailed or delivered to the Division of Welfare-to-Work, Employment and Training Administration, 200 Constitution Avenue, NW., Room N–4671, Washington, DC 20210, *Attention:* Dennis Lieberman. Comments may also be submitted electronically by accessing the WtW web address at *http://wtw.doleta.gov/amendcomments/default.htm.*

All comments will be made available for public inspection and copying during normal business hours at the above address.

FOR FURTHER INFORMATION CONTACT: Mr. Dennis Lieberman, Division of Welfare-to-Work, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N–4671, Washington, DC 20210. Telephone: (202) 693–3910 (voice) (this is not a toll-free number) or 1–800–326–2577 (TDD).

SUPPLEMENTARY INFORMATION: This preamble is divided into four sections. Section I provides general background information. Section II discusses the Final Rule promulgated in response to comments received on the November 18, 1997, IFR1. Section III discusses the new IFR2, implementing changes to the WtW statute made by the 1999 Amendments. Section IV discusses miscellaneous administrative requirements, *e.g.,* Paperwork Reduction Act requirements.

In addition to the changes made based upon the comments received, in order to clarify policy and interpretation, we have also made technical changes to correct typographical errors, such as consistent capitalization, abbreviations, grammatical corrections and citations, consistency with the regulations implementing the nondiscrimination and equal opportunity provisions of WIA section 188, which was first published in the **Federal Register** on November 12, 1999 (64 FR 61692 through 61738, 29 CFR part 37). When publishing a final rule following comment period, it is customary to publish only changes made to the rule, however, in order to be more user-friendly, we are publishing the entire Rule, including the changes made by IFR2 as well as those parts that have not been changed from IFR1. This means that one document which contains all of the regulations may be consulted rather than needing to compare various documents.

I. Background

Final Rule

On November 18, 1997, the Employment and Training Administration (ETA) published IFR1 in the **Federal Register** to establish the administrative framework for the Department's Welfare-to-Work (WtW) program. IFR1 also provided an opportunity for public comment. Comments were received from 88 entities. The commenters included: 25 State government agencies, 6 city and/or local government agencies, 3 Federal agencies, 10 Private Industry Councils (PICs), 14 local service providers, 4 private companies, 2 labor unions, 1 university and 16 non-profit associations. Of the 16 non-profit associations, 3 are national, bipartisan associations representing State legislatures, governors, or county agencies, 7 are legal-aid associations, and 2 are research institutions. Responses also came from 7 other sources, including private citizens.

We have reviewed and fully considered these comments in developing the Final Rule. The issues raised are addressed, where appropriate, in the Summary and Explanation of this Final Rule (Section II, below). Provisions of the IFR1 that neither elicited comments nor were affected by subsequent legislative action are not addressed in the discussion the Final Rule. Those provisions are addressed in the Summary and Explanation of IFR1, published at 62 FR 61589–61602 (Nov. 18, 1997).

Interim Final Rule (IFR2)

The Clinton-Gore Administration worked closely with Congress to enact the 1999 Amendments that make several significant changes to the WtW grant programs. These significant changes include changes in the eligibility requirements for both long-term welfare recipients and non-custodial parents of low-income children, an addition to the list of allowable activities that may be conducted under WtW, and the streamlining of WtW reporting requirements. The 1999 Amendments took effect on January 1, 2000, for competitive grantees and on July 1, 2000, for formula grantees, although with certain restrictions on outlays of Federal WtW funds until October 1, 2000. For Indian and Native American WtW grantees, the 1999 Amendments were effective on the day of enactment, November 29, 1999.

To allow for public comment, we are issuing the regulatory provisions promulgated as a direct result of the 1999 Amendments as a new Interim Final Rule. The new provisions open for comment under the IFR2 are discussed below in Section III of this preamble.

Note: As this document went to press, the DOL/HHS/Education Appropriations bill for FY 2001 was enacted, containing provisions

to extend by two years the period in which WtW grant funds may be spent and to delete the authority for the $50 million for performance bonuses. We have retained the performance bonus criteria in this Rule in the event of future funding for this purpose, but no bonus grants will be made in FY 2001.

II. Summary and Explanation—Final Rule

This section contains a discussion of the comments we received during the comment period established in the November 18, 1997, IFR1. The headings in this section are the same as they appeared in the IFR1 for ease of reference. Many of the comments on IFR1 addressed areas which were changed by intervening technical amendments to the WtW statute. For example, on November 13, 1997, shortly before the publication of the IFR1, Congress extended, to three years, the time period for the expenditure of WtW matching funds (originally discussed in § 645.320) (Pub. L. 105–78). Congress also changed the time period for obligating WtW funds after a grant award (originally discussed in § 645.320) from one to three years, and made this change retroactive to the date of passage of the Balanced Budget Act of 1997 (Pub. L. 105–33), *i.e.,* August 5, 1997. The main concerns commenters raised about the eligibility criteria for noncustodial parents in § 645.212 were initially resolved through a technical amendment included in the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200) and later superseded by the 1999 Amendments discussed in Section III of this preamble. President Clinton's FY 2001 budget has proposed providing grantees an additional two years to spend existing resources.

The Transportation Equity Act for the 21st century (TEA–21) (Pub. L. 105–178) allows the Federal WtW funds to be used as matching funds for the Department of Transportation's ''Job Access and Reverse Commute'' program.

Under Pub. L. 105–277 (Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999), Congress made changes to the WtW program to reflect the transition from the Job Training Partnership Act (JTPA) (Pub. L. 97–300, as amended, 29 U.S.C. 1501, *et seq.*) to the Workforce Investment Act of 1998 (WIA) (Pub. L. 105–220, 29 U.S.C. 2801, *et seq.*). These changes are reflected in new or revised definitions under § 645.120 regarding the particular circumstances of the different service areas.

Summary of Changes in the Final Rule

Some commenters suggested that we provide more specific direction, especially about identifying allowable program activities and allowable items for State matching funds. Other commenters recommended that we clarify and expand the workforce protections available to the participants in the program. Those recommendations received careful consideration and revisions were made, where appropriate, as discussed in the Summary and Explanation (Section II, below).

Many commenters recommended changes in the IFR1 provisions, such as those establishing eligibility and the ''work first'' approach, that could not be accommodated because the suggested changes would be inconsistent with the underlying statute. Congressional action would be required to accommodate these comments.

The WtW program will operate during the period in which the Workforce Investment Act supersedes the Job Training Partnership Act. WIA requires significant changes in the workforce development system at the State and local levels. The WtW program is a required partner in the One-Stop system, which is the basic service delivery system for the new workforce investment system. This system is intended to provide services to all individuals seeking assistance, including welfare recipients. The participation of the WtW program in the One-Stop system will entail cooperative relationships with other agency partners through memoranda of understanding (MOU). Although WtW is separately funded, One-Stop centers will operate so that individuals receive a seamless array of services. A final rule implementing WIA was published in the **Federal Register** on August 11, 2000 (20 CFR parts 652, 660–671). The WtW Final Rule adds guidance at §§ 645.220 and 645.430 about the relationship between WtW and the One-Stop delivery system under WIA in response to comments on how the two programs will interact. Also, the WtW IFR1 definition of ''administrative costs'' has been revised so that it more closely parallels the concept of functionality in the definition of this term at 20 CFR 667.220 of the WIA regulations.

Also, this Final Rule acknowledges the definitions contained in the new Temporary Assistance for Needy Families (TANF) regulations published in the **Federal Register** on April 12, 1999 (45 CFR part 260, *et seq.*). Specifically, the TANF regulations define ''cash assistance'' at 45 CFR 260.30, and explain the terms ''assistance'' and ''WtW cash assistance'' at 45 CFR 260.31 and 260.32, respectively. Many comments on the WtW IFR1 related to the subject of ''assistance'' due to its effect on the TANF five-year time limit and WtW eligibility. We formulated a definition of ''TANF assistance'' for use in WtW eligibility determination guided by the Department of Health and Human Services' (DHHS) new TANF regulations and we refer to that rule in our response to comments. This change is discussed in more detail below.

Finally, we note that the 1999 Amendments have superseded, in some cases, changes we might have made strictly in response to the comments. The 1999 Amendments have made significant changes which simplify the WtW eligibility criteria, for example, which require new provisions, those are established in the IFR2. Section III of this preamble discusses the new regulatory provisions which are open to public comment as a result of the 1999 Amendments.

Responses to Specific Comments on IFR1

Subpart A—Scope and Purpose

What Definitions Apply to this Part? (§ 645.120)

Section 645.120 sets forth definitions applicable to the Welfare-to-Work program. The phrase ''political subdivisions of a State,'' identified in § 645.500 as eligible applicants for competitive grants, was not defined. One commenter notes that the varied terms for ''political subdivision'' used in the Solicitation for Grant Applications (SGA) for competitive grants, such as ''political subdivision of a State,'' and ''unit of general purpose local government,'' are confusing, and suggested that we define this phrase.

Response: We agree that the terms used to describe eligible applicants for competitive grants should be consistently defined in the SGA and the regulations, and have included a definition for the phrase ''political subdivision'' in the Final Rule. Under this new provision, ''political subdivision'' means a unit of general purpose local government, as provided for in State laws and/or Constitution, which has the power to levy taxes and spend funds and which also has general corporate and police powers. This definition is consistent with the definition in the SGA for Welfare-to-Work Competitive Grants published in the **Federal Register** on January 26, 1999.

For similar reasons, the definition of ''private entity'' which appeared in the January 26, 1999, SGA has been added to § 645.120 in the Final Rule, so that the meaning of the term is clearly expressed. ''Private entity'' means any organization, public or private, which is not a Local Board, PIC or alternate administering agency or a political subdivision of a State.

Another commenter suggested that the Department amend language used throughout the IFR1 to include ''or alternate administering agency'' after each reference to a (PIC). The commenter was concerned that readers would believe that only PICs serve as WtW administering agencies. As noted in § 645.210 of the IFR1, an alternate administering agency is one designated by the Governor and approved by the Secretary under § 645.400 of this part.

Response: For the sake of clarity, we have made the suggested change, but have generally replaced the term ''PIC'' with the WIA term ''local board'' in this phrase. Under WIA (Pub. L. 105–220) (20 CFR, Part 652, et al.) passed in August, 1998, local workforce investment boards (local boards) have replaced PIC's in most places, and the JTPA service delivery areas used by the WtW program may undergo change as WIA is implemented and local workforce investment areas are designated in their place. Also, Pub. L. 105–277 (Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999) amended the Social Security Act (SSA) to revise the WtW definitions of PIC (section 403(5)(D)(ii)), Service Delivery Area (section 403(5)(D)(iii)), and Chief Elected Official (section 403(5)(A)(vii)(I)). Therefore, in light of the legislative changes and the comment discussed above, the corresponding IFR1 definitions have been revised so that they refer to both the JTPA and WIA terminology in order to bridge the transition from JTPA to WIA. In this preamble, however, we generally use the term ''local board'' to refer to these entities.

Definition of TANF Assistance. The WtW program exists within the larger framework of the TANF program administered by DHHS which provides benefits in the form of cash or other assistance to eligible families and individuals, as well as a range of benefits and services consistent with the goals of the TANF law. In the preamble of IFR1, we stated that we would follow the lead of DHHS in defining certain terms, including ''assistance.'' What constitutes ''assistance'' is a major consideration both in applying the Federal 60-month time limit on receipt of TANF benefits and in determining eligibility for WtW. Therefore, we received numerous comments seeking clarification, particularly with regard to what constituted ''WtW cash assistance.''

One commenter stated that the definition proposed by DHHS showed intent to include wage subsidies in the definition of assistance, including payments to employers to help cover the costs of employment or on-the-job training. The commenter disagreed with this approach and requested that such subsidies not be treated as assistance. Rather, the commenter suggested, they should be viewed as tax incentives which would not be considered assistance even if funded with TANF funds. Since DHHS defines assistance as benefits or services that would be considered welfare, the commenter suggested that activities under TANF that help pay for jobs that pay wages and confer employee status should be considered non-assistance, as should wage-paying publicly funded jobs created for recipients.

Another comment stated that Congress distinguished between cash and non-cash assistance when it established the WtW program and that cash assistance, not non-cash assistance, should count against the five-year TANF limit. Further, the comment indicated that it is unclear whether child care would be considered cash assistance and thus count against the time limit. It suggested that the Final Rule provide clearly that child care is non-cash assistance, citing the precedent of the Food Stamp Program. This would enable WtW participants to receive child care through WtW without exhausting their TANF eligibility.

Response: The DHHS has issued definitions for ''assistance'' and ''WtW cash assistance'' for use in the TANF program, at 45 CFR 260.31 and 260.32, respectively, published in the **Federal Register** on April 12, 1999 (64 FR 17720). In 45 CFR 260.31, the DHHS defines the term ''assistance'' to generally mean cash payments, vouchers, and other forms of benefits to meet a family's basic needs for food, clothing, shelter, etc. Exclusions from ''assistance'' include non-recurrent short-term benefits, wage subsidies to employers, supportive services for families who are employed, services such as counseling, case management, child care, and other job retention and employment-related services that do not provide basic income support. However, supportive services such as transportation and child care are included for families who are not employed. (See TANF Final Rule for full text).

The term ''WtW cash assistance,'' as defined in 45 CFR 260.32, includes the benefits defined as assistance in 45 CFR 260.31 that are directed at basic needs. Such benefits are included when they are provided in the form of cash payments, checks, reimbursements, electronic fund transfers, or any other form that can legally be converted to currency. The TANF Final Rule became effective on October 1, 1999. The TANF definitions are promulgated by DHHS; we cannot change them for purposes of TANF.

However, we have determined that a definition of what it means to receive ''TANF assistance'' for the purposes of determining eligibility for the WtW program, as distinct from the definition as it relates to TANF time limits, work participation and other requirements, is necessary in order to respond to the comments and concerns about the potential negative impact the final DHHS definition could pose for certain individuals in the WtW target groups. The DHHS definition of ''assistance'' and ''Welfare-to-Work cash assistance'' in the TANF Final Rule would preclude from participation in WtW persons who are receiving services such as counseling and case management and/or employment-related services such as job retention, that do not provide basic income support. Although the definition of ''WtW cash assistance'' in the TANF final regulations still stands for the purpose if the TANF time clock, for the purposes of determining if a person is receiving TANF assistance as a condition of WtW eligibility, we consider the phrase ''TANF assistance'' to mean ''any TANF benefits and services for the financially needy according to the appropriate income and resource criteria (if applicable) specified in the State TANF plan.''

The funding sources for the TANF benefits and services an individual receives may be either Federal TANF funds or State Maintenance of Effort (MOE) funds expended in the TANF program.

As this phrase is applicable to WtW for narrow eligibility purposes only, we have not added it to the definition section of this rule at § 645.120. Rather, it is incorporated into the Rule at § 645.212(d) and applies only to eligibility determinations under §§ 645.212(a)(1) and 645.213(a).

This provision should allow these otherwise eligible individuals to participate in WtW and alleviate some of the main concerns commenters had about how ''assistance'' is defined. Those who are served under WtW

because of the new provision at § 645.212(d) must be among the financially needy as determined by the State TANF plan. If there is no means test for the benefits and services a particular individual receives under TANF, the individual will be considered to be financially needy for purposes of eligibility under this provision at § 645.212(d). If there is a means test, the individual must meet the income and resource criteria established by the State for the particular benefits or services.

Subpart B—General Program and Administrative Requirements

Who May be Served as a Hard-to-Employ Individual Under the 70 Percent Provision? (§ 645.212)

The 70 percent eligibility criteria for a ''hard-to-employ'' individual under § 645.212 of IFR1 tracked the underlying statutory language then in place. Paragraph 645.212(a) required that the individual must be receiving TANF; must face at least two of three specified barriers to employment (has not completed secondary school or obtained a certificate of general equivalency; requires substance abuse treatment for employment; and/or has a poor work history); and must be a long-term TANF recipient (at least 30 months receipt of TANF or must be within 12 months of a Federal or State time limit on TANF eligibility). Paragraphs 645.212(b) and (c) set the criteria for serving non-custodial parents and individuals who no longer receive TANF due to a Federal or State time limit on eligibility. Also, we have added a new paragraph (d) to reflect that for purposes of WtW eligibility, TANF assistance will mean, ''any TANF benefits and services for the financially needy according to the appropriate income and resource criteria (if applicable) specified in the State TANF plan.'' For a full discussion of this meaning of assistance that is applicable to WtW for eligibility determination purposes, see ''Definition of Assistance'' above in the discussion of § 645.120.

The 1999 Amendments significantly changed the eligibility criteria for participants served under § 645.212 by removing the barrier requirements, but, as described in the discussion of § 645.211 in Section III of this preamble, retained the requirement that at least 70 percent of a project's funds be used to serve participants meeting the criteria of § 645.212. Generally, at least 70 percent of a project's WtW funds must be spent on long-term welfare recipients (without a requirement that they face barriers to employment) and noncustodial parents meeting certain criteria. Our discussion of these changes in Section III of the preamble presents a complete analysis of these changes and the resulting changes to the regulatory eligibility criteria in § 645.212. Many of the comments on the hard-to-employ criteria of IFR1, summarized below, are no longer relevant because the 1999 Amendments eliminated the criteria addressed by the comments, but we have presented them to reflect the concerns expressed by the interested parties. Some of the comments on IFR1, however, raise issues regarding the length of receipt of TANF assistance, which are still relevant to the revised § 645.212. In response to these, we have made two other changes to § 645.212.

Under IFR1, among the eligibility criteria under the 70 percent provision, § 645.212(a)(3)(ii) provided that an individual must be within 12 months of a Federal or State-imposed durational time limit on eligibility. An individual could meet this requirement if (s)he would have been within 12 months of such a durational time limit but was exempted from the limit due to a hardship exemption under section 408(a)(7)(C) of the Act. Section 645.212(c) provides that an individual who otherwise meets the criteria of § 645.212 may be served if (s)he is no longer receiving assistance due to a Federal or State-imposed lifetime limit on assistance.

We received several comments regarding the use of the terms ''State-imposed durational time limit'' and ''State-imposed lifetime limit'' in § 645.212. Commenters suggested that we replace them with a phrase such as ''State-imposed time limit'' because not all States impose durational time limits or lifetime limits and many States have instituted intermittent time limits within the lifetime limit of five years. A commenter noted that in one State an individual's lifetime of TANF assistance could span a seven-year time frame, as assistance could be provided for 36 months, break for two years and then resume for an additional 24 months and that, under these circumstances, an individual would not be eligible for WtW under § 645.212.

Response: We agree that our use of these terms may have had unintended consequences due to variation in the way limits are applied throughout the States. As the lifetime limit criterion is still relevant under the 1999 Amendments, we have replaced references to ''State lifetime limits'' with the phrase ''State-imposed time limits'' in §§ 645.212 and 645.213.

A commenter suggested that we revise § 645.212 to provide that victims of domestic violence, addressed by section 402(a)(7) of the Act, would be eligible for WtW services even if exempt from the durational limits on receipt of TANF services.

Response: Section 402(a)(7) of the Act provides that State TANF plans may provide for waiver of certain requirements, including time limits, when compliance with the time limits would make it more difficult for the TANF recipient to escape from domestic violence. We agree that where an individual is within 12 months of the State limit, but has received such a waiver, it would make no sense to deprive the person of WtW assistance simply because the individual is exempt from the State limit due to a domestic violence waiver instead of a hardship exemption. Accordingly, we have revised § 645.212(a) to refer to section 402(a)(7) of the Act, to make it clear that victims of domestic violence who have received a waiver of the State-imposed time limit, like individuals who are exempted from the limit because they have been battered or subjected to extreme abuse, may be served under WtW (other changes to § 645.212(a) made by IFR2 are discussed in Section III of this preamble).

Many of the other comments we received on § 645.212 made valid points, but the issues raised are no longer relevant because of the simplification of the eligibility criteria under the 1999 Amendments. In particular, the barriers to employment provisions of sect; 645.212(a)(2) generated significant comment. Under the new eligibility criteria, long-term welfare recipients who are served under the 70 percent provisions are not required to demonstrate that they face these barriers. Below, we have briefly summarized and discussed comments on the 70 percent criteria in general and the barriers to employment in particular, but, because they are no longer required as eligibility criteria, we have not responded in great detail.

While most comments addressed the specific barriers to employment, several comments were more general in nature. Comments suggested that we revise the regulations to provide that an individual would be eligible if the individual satisfied any one of the three barriers instead of at least two of the three barriers. A commenter stated that persons with disabilities should be included among the hard-to-employ, because many people with disabilities are long-term welfare recipients. The commenter suggested that we amend 645.212(a)(2) by adding a fourth barrier to specifically cover persons with disabilities that affect their ability to

obtain/retain employment or by expanding the definition of poor work history to include poor work history due to a disability.

Response: Prior to the 1999 Amendments we could not have made these changes, although an individual meeting the poor work history criterion could be served regardless of the reason for the poor work history. Thus, an individual with a poor work history caused by a disability could be eligible if the other criteria were met. Under the 1999 Amendments, the barriers criterion is eliminated. We expect that long term welfare recipients with disabilities will be served under the new eligibility criteria. Moreover, our competitive grant SGA's and formula grant planning instructions have encouraged State and local operating entities to give priority consideration to individuals with disabilities

Education Level (§ 645.212(a)(2)(i)). IFR1 provided that individuals who had neither completed secondary school nor obtained a certificate of general equivalency and who had low skills in reading or mathematics satisfied the education level eligibility criterion of § 645.212(a)(2)(i). Several commenters viewed this provision as overly restrictive, and suggested we revise the criterion so that it can be met by a showing that a participant meets either of the criteria. Commenters supported this suggestion with the observation that a high school diploma or equivalency did *not* guarantee that an individual had the requisite skills.

Other comments recommended that the reading and mathematics skill level not be defined at the 8.9 grade level or below, but that operating entities be able to set grade skill levels based upon local labor market requirements, or that the threshold be raised to a higher grade level. Commenters recognized that the 8.9 grade level was consistent with similar criteria in JTPA, but suggested that WtW's relationship with TANF argued for flexibility to diverge from JTPA.

Response: Based upon these comments, we tend to agree that the regulatory definition standards for the educational ability criterion may have been overly restrictive. In any event, under the new criteria set forth in IFR2, educational ability is no longer a criterion for eligibility of long-term welfare recipients.

Poor Work History (§ 645.212(a)(2)(iii)). The IFR1, at § 645.212(a)(2)(iii), defined ''poor work history'' generally as no more than 3 consecutive months worked in the past 12 calendar months. Commenters opined that this definition was overly restrictive and/or not an appropriate indicator of a poor work history. Some commenters provided anecdotes regarding individuals who, having worked part-time or through a program, would be ineligible for WtW under this definition, and proposed that States should be permitted to adopt their own definitions of poor work history.

Commenters identified other perceived problems with the regulatory definition of poor work history:

- Individuals who have had a series of short spells of work covering three consecutive months would be ineligible despite demonstrating an inability to keep a job;
- The definition did not establish a required number of work hours in the three-month period;
- The definition would exclude hard-to-employ individuals who had only a part-time summer job within the last 12 months as well as the working poor and seasonal workers.

Other commenters recommended revisions, some to conform with the JTPA and some to follow the pre-TANF Unemployed Parents regulations. Most requested that the Department obtain a more complete picture of an individual's work history by going back further in time.

Several commenters asserted that the three consecutive months criterion is inconsistent with the requirement that at least half of the payment to service providers for job placement services occur after a participant placed in a job has worked for six months. To these commenters, those provisions indicated a Congressional determination that holding a job for less than six months was evidence of a poor work history.

Response: Like the educational ability criterion, we tend to agree with commenters that the regulatory definition of ''poor work history'' may have been overly restrictive. In any event, under the new criteria set forth in IFR2, poor work history is no longer a criterion for eligibility of long-term welfare recipients.

Length of Receipt of TANF Assistance (§ 645.212(a)(3)). A commenter asked if individuals who have been diverted from receiving TANF as part of a State's diversion strategy are eligible for WtW.

Response: Individuals who might otherwise be eligible for WtW services, but who have been diverted (may have received one-time only financial assistance, for example) are not eligible for WtW under the old or new provisions of § 645.212 because they are not eligible for TANF. Even as amended, receipt of TANF assistance is the basic criterion for WtW eligibility. Operating entities should assess whether diverted individuals may qualify under other criteria, such as the criteria for noncustodial parents at § 645.212(c) or under § 645.213 as an individual formerly in foster care or a low income custodial parent. These new eligibility criteria are more fully discussed in Section III of this preamble.

Noncustodial Parents (§ 645.212(b)). The IFR1 stated that a noncustodial parent would be eligible if the custodial parent met the eligibility requirements of paragraph (a) of § 645.212. Commenters asserted that this approach posed insurmountable difficulties for those entities who were in contact only with the noncustodial parent.

Response: The 1999 Amendments address this issue. The statutory and regulatory changes that address these concerns are described below.

A technical amendment, enacted on July 16, 1998, as part of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105–200), changed the eligibility criteria for noncustodial parents under § 645.212. This amendment revised the language of SSA section 403(a)(5)(C)(ii) to apply the barriers to employment criteria to all participants, including noncustodial parents. In addition, the amendment clarified that the required length of receipt of cash assistance under TANF applies to either the custodial parent or the minor children of the noncustodial parent. The addition of the reference to the minor child of the noncustodial parent addresses those ''child only'' cases where there is no custodial parent and also allows WtW to provide services to a noncustodial parent whose children are less than 30 months old, if the custodial parent has been on TANF for a longer period.

We issued Training and Employment Guidance Letter (TEGL) No. 6–98 on September 21, 1998, to convey this change and have posted this information on the WtW website. Subsequently, we issued TEGL 6–98 Change 1 on December 17, 1998, to address those cases where there are custodial caretaker relatives who receive TANF benefits for themselves and on behalf of the children in their custody. While the number of these cases nationwide is small, these custodial caretaker relatives are subject to the same TANF participation requirements and time limitations as other TANF recipients and therefore may be eligible for the WtW program.

The 1999 Amendments contain eligibility criteria pertaining to noncustodial parents that supersede the earlier statutory and subsequent technical changes. Section III of this preamble fully discusses the new

eligibility criteria for noncustodial parents.

Who May Be Served as an Individual With Long-Term Welfare Dependence Characteristics Under the 30 Percent Provision? (§ 645.213)

This section of IFR1 stated the requirements for enrolling participants, under the 30 percent provision, as ''individuals with long-term welfare dependence characteristics.'' As with § 645.212, commenters raised issues regarding time limits and State-to-State eligibility variations.

A commenter recommended that we revise this section to provide that individuals would be eligible if they *either* are receiving TANF assistance or have one or more characteristic of long-term welfare dependence. Another commenter suggested that we include a history of domestic violence as an example of a characteristic associated with long-term welfare dependence, citing studies in support of that viewpoint. Another suggested that we add having a disability affecting the ability to obtain and retain employment to the list of characteristics associated with or predictive of long-term welfare dependency.

Response: These changes have not been made, because they are not needed. Under IFR1, States, in consultation with the operating entities, already have the flexibility to identify characteristics associated with or predictive of long-term welfare dependence such as those suggested, in addition to those provided in the regulation. Under the 1999 Amendments, discussed in Section III of this preamble, this flexibility is maintained.

How Will Welfare-to-Work Eligibility Be Determined? (§ 645.214)

A commenter recommended that we change the language in § 645.214 (b)(2), to permit a determination of eligibility to be ''based on information collected by the operating entity *and/or* the TANF agency'', in order to address those situations where State TANF agencies and operating entities share responsibility.

Response: This editorial change has been made for the sake of clarity.

What Activities Are Allowable Under This Part? (§ 645.220)

A significant number of commenters asserted that the ''work first'' philosophy undermines the successful transition of WtW participants to unsubsidized employment, by placing participants into jobs before they have received the training in basic and occupational skills needed to prepare them to succeed at those jobs.

Response: We have not made any changes to the regulations based on these comments, because the ''work first'' requirements implement our understanding of the intent of the WtW legislation and the purpose of the program. While we acknowledge that the design and implementation of work-first programs can pose challenges, the purpose of the WtW program is to place participants in employment activities which will then lead to unsubsidized employment and long-term self-sufficiency. We also believe that the statute and the rule provide significant flexibility to combine work with training and other post-employment services that will help participants to build skills needed to succeed and advance in the workforce.

Some commenters supported the IFR1's flexibility in the definitions of allowable activities, while others favored a more prescriptive approach. The terms that elicited particular interest were ''job readiness'', ''job placement'', ''on-the-job training'', ''community service'', ''work experience'', ''job creation'', ''post-employment activities'', ''job retention'', ''supportive services'', ''assessment'', and ''Individual Development Accounts'' (IDAs).

Response: We continue to believe that the States and localities should have the flexibility to develop definitions that fit their circumstances, therefore, we have not further defined these terms. We have formalized this flexibility in IFR2 by adding a new § 645.125 to describe the roles of Federal, State and local governmental partners in the governance of the WtW program. This section is discussed in section III of this preamble.

Several commenters recommended we modify § 645.220(e) so that supportive services could be provided to participants who are receiving job placement services.

Response: We agree that it is appropriate for operating entities to be able to provide supportive services for individuals participating in job placement activities. Section § 645.220 has been modified accordingly.

A commenter noted that language used throughout WtW and JTPA recommends and mandates coordination of program activities and non-duplication of services. This principle is also true of the Workforce Investment Act, under which workforce investment systems have replaced the job training systems created under JTPA. Under JTPA, the goal of coordination was achieved by utilizing resources outside of the funding source to supplement and extend services to the greatest number of participants possible, the commenter points out. The commenter recommends that funds from programs under WIA or JTPA or others available through the One Stop system should be available for WtW activities, and that WtW funds be used to provide supportive services for individuals engaged in activities under WIA, JTPA or other funding streams.

Response: We concur that better coordination between the WtW system and the One-Stop system developed under JTPA/WIA is beneficial to all programs, and have added language to § 645.220(f) that explains that job retention and support services may be provided to eligible WtW participants who are enrolled in WIA or JTPA activities (including occupational skills training). We seek to foster such coordination, especially as the WtW program is a required partner in the One-Stop system created under WIA. These services can be provided with WtW funds when they are not otherwise available to the participant. Furthermore, we have added a new section 645.430 (which is discussed below in this section II of the preamble) to more fully describe the role of WtW in the One-Stop system.

Several commenters indicated support for the expanded use of WtW funds to provide medical services.

Response: Section 408(a)(6)(A) of the SSA specifically prohibits the use of any TANF funds, including WtW funds, for medical services, so we have not made the suggested change. An explanation of this prohibition is available in the Q & A's on the WtW website, at number AA8, under ''Allowable Activities.''

Based upon inquiries received from other sources, the Department has posted a Q&A to set forth our interpretation that § 645.220(h) permits outreach and recruitment activities as part of the allowable program activities listed in paragraphs (a) through (f) of § 645.220. Costs associated with these activities must be reported in the same category as intake, assessment, eligibility determination, development of an individualized service strategy and case management identified at § 645.220(h). We have changed § 645.220(h) to clarify that these outreach and recruitment activities are allowable uses of WtW funds.

Under IFR1, occupational skills training activities could only be provided as a post-employment activity for individuals placed in a job or a WtW employment activity. Under the 1999 Amendments, short-term vocational educational training or job training are

permissible activities. This is discussed in more detail in section III of this preamble.

Finally, as a technical correction, we have removed the phrase ''but not limited to'' from this the list of suggested post-employment services and job retention and support services in this section. This does not change the meaning of this provision. Here, as throughout the regulations, the term ''include'' is used to indicate an illustrative, but not exhaustive list of examples. We also removed the reference to SSA section 404(h) in § 645.220(f) to emphasize that IDAs established in accordance with statutory purposes or uses of TANF and WtW are allowable WtW activities.

What General Fiscal and Administrative Rules Apply to the Use of Federal Funds? (§ 645.230)

The information technology provision of § 645.235(c)(3) has been moved to § 645.230(d) to relate it to the discussion of allowable costs. As a result, paragraph 645.230(d) is redesignated as paragraph (g) in the Final Rule and the remaining paragraphs have been redesignated accordingly. This is discussed further in the discussion of § 645.235, below.

Commercial Organizations. A commenter noted that the IFR1 did not specify fiscal and administrative requirements for commercial organizations.

Response: The final rule clarifies, in § 645.230 (a)(2), that commercial organizations, along with non-profit organizations, must follow OMB Circular A–110, codified at 20 CFR, Part 95. A similar provision, clarifying the audit requirements for commercial organizations, has been added at § 645.230(b).

Six-Month, 50 Percent Hold-back on Contracts and Vouchers. Several commenters asked for clarification and guidance on § 645.230(a)(3), requiring that contracts and vouchers include a provision that at least one-half of the payment for job placement services occur after an eligible individual has been placed into the workforce for six (6) months. For example, some comments raised questions about the meaning of the phrase ''placement in the workforce'' during the six-month hold-back period. Others wondered whether the six months must be either continuous or cumulative, whether participants had to remain with a single employer during the entire period, whether part-time or subsidized employment could count towards the six months and whether reasonable transition time between jobs could be considered part of the six-month hold-back period.

Response: We have provided guidance that retention for six months in the workforce is achieved when a participant is placed in unsubsidized employment and receives earnings in the two consecutive quarters following the quarter in which placement occurred in the instructions for the WtW Formula Grant Cumulative Quarterly Financial Status Report (ETA 9068). Under these instructions, participants do not have to remain with a single employer during the entire period, and no minimum number of hours or level of earnings is specified.

A commenter asked for guidance as to which contracts and vouchers are subject to the six-month hold-back provision. Other commenters suggested that we waive the six-month hold-back requirement under certain circumstances.

Response: The mandatory six-month hold-back provision applies to all contracts and vouchers for placement services into unsubsidized jobs, except for those placement services that are provided to individual participants as a reasonable and necessary part of the operating entity's work experience, community service and/or on-the-job training program. This provision is mandated by statute and can not be waived for PICs and local boards. Under the 1999 Amendments, competitive grantees who are not PICs or local boards may provide services directly. See further discussion in section III of the preamble.

A number of commenters inquired whether fixed unit price performance-based contracting can be used under WtW. One commenter questioned whether the regulations reflect DOL policy with regard to fixed-unit-price contracts. Another commenter recommended that the regulations not impose additional restrictions upon fixed-unit-price contracts over and above the hold-back requirement.

Response: We see this contracting method as appropriate, especially in conjunction with the six-month hold-back requirement for performance. We have provided guidance on fixed unit price performance-based contracts and the requisite reporting requirements in the Q & A's on the WtW website *(http://wtw.doleta.gov/q&a/administrative.htm)* at numbers AF17 and AF18, under ''Administrative/Fiscal.''

Program Income. Commenters expressed concern that the regulations prohibit profits as an allowable use of funds, and asked whether a non-profit may earn a profit or whether all earnings must be reported as program income.

Response: For the sake of clarity, a new paragraph has been added to § 645.230(a)(6) which requires governmental or non-profit organizations that earn excess revenue over costs incurred to treat the excess revenue as program income earned, and report it as such. The regulation imposes no additional restrictions on fixed-unit-priced contracts or on program income derived from such contracts. It only clarifies the treatment of income earned by governments or non-profit organizations from fixed-unit-price contracts or other sources.

One commenter requested further clarification of the addition method, which is addressed in § 645.230(a)(5).

Response: The Final Rule adds a reference, in this section, to 29 CFR 97.25(g)(2), which describes the addition method. 29 CFR 97.25(g)(2) clarifies that under the addition method, program income is added to the available WtW grant funds and must be used for the purposes and under the conditions set forth by the grant agreement. Section 97.25(g)(2) also explains both the net and gross income methodologies for determining the amount of program income to be credited to the grant program.

Audit Requirements. As some comments noted, the IFR1 did not address the responsibility for audits of commercial organizations. Section 645.230(b) has been revised accordingly. A new paragraph (b)(3) is added to § 645.230 to establish that the Department is responsible for audits of commercial organizations that are direct recipients of WtW grants. In addition, commercial subrecipient organizations that spend more than the threshold level specified in 29 CFR part 99, which implements OMB Circular A–133 ($300,000 as of publication of this rule), must conduct either an organization-wide audit or a program-specific financial and compliance audit, as required by 29 CFR part 99.

Drug-Free Workplace Requirements. Paragraph (d) in § 645.230 of the IFR1 establishes that all WtW recipients and subrecipients must comply with government-wide requirements for a drug-free workplace. One comment, citing the provisions at 29 CFR 98.600, questioned whether the drug-free requirements should apply to both the recipient and subrecipient level, or should apply only to the recipient level.

Response: We have divided § 645.230(g) into two paragraphs, (g)(1) and (g)(2), to clarify how drug-free workplace requirements are to be

applied, at the recipient and subrecipient levels, respectively.

Prohibition on the Construction or Purchase of Facilities and Business Start-up Costs. The WtW statute specifies the allowable activities for the formula and competitive grant programs at section 403(a)(5)(C)(i). The statute does not include the construction or purchase of facilities or buildings as allowable activities. Section 645.300(b)(1)(i) elaborates on this general prohibition on facilities expenses by specifying that the cost of constructing or purchasing facilities or buildings is not acceptable as match for a WtW formula grant. This is because match expenditures are only acceptable when spent on those costs which would be allowable if paid for with WtW grant funds, and because Federal funds may be used for such facilities expenses only where there is specific legislative authorization. Since WtW does not specifically authorize these expenses, they are not allowable WtW expenditures nor acceptable match. However, the IFR1 inadvertently failed to include comparable language explicitly barring the use of formula grant funds or competitive grant funds to construct or purchase facilities or buildings.

We are concerned that the apparent discrepancy could be misunderstood. Therefore, we added a provision at § 645.230(e) to fix this oversight and indicate clearly that the same limitations on the use of WtW funds for the construction or purchase of facilities or buildings apply to competitive grant funds and to formula grant funds.

Similarly, we wish to clarify that WtW funds generally may not be used to cover the costs of starting a business or for capital ventures. In response to a recommendation by a commenter that business start-up funds be provided by the WtW program, we have added a new provision in the Final Rule at § 645.230(f) that states that WtW funds may not be used to cover these types of costs. We note, however, that there is a limited exception to this prohibition when WtW funds are used for Individual Development Accounts. These accounts, which are established by or for participants under § 645.220(f), are permitted for the purpose of business capitalization, as well as other specified purposes.

What Types of Activities Are Subject to the Administrative Cost Limit on Welfare-to-Work Grants? (§ 645.235)

WtW Definition of Administrative Costs. The IFR1 adopted the definition of ''Costs of Administration'' from the JTPA regulations at 20 CFR 627.440, and noted that the Secretary might issue further rules to conform to similar provisions in the final regulations governing the TANF program. Two commenters recommended adopting the TANF description of administrative costs to reduce administrative confusion and costs and to encourage cooperation between TANF-funded and WtW-funded programs. Other commenters recommended not adopting the TANF definition of administrative costs, because of the number of activities that are considered administrative costs under TANF. One commenter considered the adoption of JTPA administrative cost definition as too permissive given the WtW 15 percent limit on administrative costs. Another commenter recommended adopting the Child Care Development Block Grant definition for administrative costs. Another commenter suggested using a single administrative cost definition for all three welfare-related programs, WtW, TANF and Child Care Development Block Grant.

Response: Since the issuance of the IFR1, WIA was signed into law, reforming the employment and training service delivery system and replacing PIC's with local workforce investment boards. Because the WtW program will be operated through the workforce investment system under WIA, as areas make the transition from JTPA to WIA, we have decided that it makes more sense to coordinate the administrative cost definition with the WIA definition rather than the TANF definition. The WIA regulations provide a definition of administrative costs that is less restrictive than the JTPA definition. To minimize burden on the local boards, by providing consistency between WtW and WIA, § 645.235 has been revised to set forth a new WtW definition of administrative costs that is to a great extent based on the WIA definition at 20 CFR 667.220. The WIA definition of administrative costs relies on the concept of function as the method to determine how a particular cost would be charged. Under this principle, administrative costs are defined as costs incurred for enumerated administrative functions by identified administrative entities for overall program management purposes. The administrative functions include but are not limited to the following activities undertaken for overall program management purposes: accounting and budgeting, financial and cash management, procurement and property management, and developing and operating systems and procedures required for administrative functions. The administrative entities include State and local workforce boards, direct WIA grant recipients, and local grant subrecipients. For additional information on covered activities and entities, see the Workforce Investment Act Final Rule.

As part of the new definition, we no longer require first-line supervisory costs to be treated as administrative costs because this function is more closely related to the provision of direct services to participants than to overall management. Similarly, we no longer require data processing costs to be charged as administrative costs; rather, these costs must be allocated based on whether the functions they support are administrative or programmatic.

Allowable Information Technology Costs. We received several comments on the composition and classification of information technology costs, but none on the allowability of such costs. As discussed above, in the discussion of § 645.230, upon reviewing these comments we decided to clarify the Year 2000 limitations applicable to the allowability of information technology costs and to move this paragraph from § 645.235(c)(3) to § 645.230(d) to follow the paragraphs on allowable costs.

The administrative cost definition at § 645.235(d) of the Final Rule details the certain information technology costs that can be excepted from the administrative cost category. A commenter asked under which cost category are information technology systems development (above and beyond costs excluded from administrative cost limit) charged.

Response: Costs that can be excepted from the administrative cost limit are any costs incurred for the lease or purchase of hardware, including installation costs, and software needed for tracking and monitoring participant activities under a WtW grant. The cost of software development related to the tracking and monitoring functions, including personnel costs associated with such software development, can also be charged to the program cost category. Those costs of systems development that do not fall under the information technology cost exemption (i.e., information technology systems that are *not* used for tracking and monitoring) may be charged to administrative costs until the administrative cap is reached. Once the administrative cap is reached, such costs must be charged to a non-Federal source.

What are the Reporting Requirements for Welfare-to-Work Programs? (§ 645.240)

The IFR1 stated that grantees would be required to provide the Department with financial data and to provide DHHS with participant data. As discussed in Section III of this preamble, the 1999 Amendments transferred the responsibility for collecting participant data to the Department and simplified these requirements. The IFR1 indicated that the Department would issue instructions for financial reporting. We received many comments with suggestions for the financial reporting instructions.

Several comments suggested that reporting requirements conform to TANF requirements as closely as possible, while others recommended that WtW establish a reporting mechanism different from TANF, in order to avoid having WtW activities count towards the 60-month TANF clock. Some comments recommended that reporting requirements should differ from those required under the One-Stop system, while others recommended using the JTPA format for reporting requirements.

Other comments recommended against requiring reporting by Fiscal Year, recommended that we minimize our reporting requirements, and suggested that the reporting instructions require the reporting of post-employment services, unsubsidized employment, and wage data.

Response: We have issued instructions and formats for on-line financial reporting that have been approved by the Office of Management and Budget (OMB). These financial reporting instructions and formats are available at the WtW website (*http://www.etareports.doleta.gov*). Reference to this website has been added to the Final Rule. Overall, grantee response has been favorable to on-line financial reporting, as it reduces the burden on recipients and subrecipients. While the Department considered other program reporting formats, such as TANF and JTPA, as we developed the WtW reporting instructions, our intention was to remain consistent with statutory requirements. Establishing a reporting system either similar to or different from TANF's would have no impact upon the applicability of the 60-month limit on TANF for WtW participants.

In addition, electronic reporting has simplified cumulative reporting by fiscal year of appropriation. Grantees are required to report expenditure data for post-employment services. Grantees are also required to report cumulative number of placements in unsubsidized employment, broken out by greater than or less than 30 hours a week. For purposes of calculating an ''earnings gain'' percentage, wage data is reported, both at the time of placement and when the participant is retained six months in unsubsidized employment.

Several comments suggested easing reporting requirements on tracking expenditures according to the 70 percent and the 30 percent eligibility categories. Two comments noted that the WtW statute imposes significant administrative and reporting burdens. They recommended that we consider the 70 percent criteria to be satisfied when 70 percent of the participants are hard-to-employ individuals, citing a precedent in JTPA Title II where at least 65 percent of participants must be ''hard-to-serve individuals.''

Response: The 1999 Amendments have resulted in a change in the original 70/30 requirements which is discussed in section III under § 645.211.

Some comments stated that the accounting requirements were overly burdensome. One comment suggested allowing States the option to choose the accounting method, employing either a cash method or an accrual method. One comment supported the use of the accrual method.

Response: States already have the option to choose which accounting method they use. However, if they use a cash method of accounting, they need to develop accrual information for reporting purposes.

The 1999 Amendments called for the simplification and coordination of reporting requirements. The Department was given the responsibility of establishing requirements for both financial and participant information. To fulfill this mandate, the Department has prepared revised reporting formats for formula and competitive grantees to include both participant and financial information.

The existing format was redesigned to reflect a streamlined approach in the reporting of both financial and participant data on one form. This data collection package will be submitted to OMB for approval separately from this rule. The status of the submission is discussed in section IV. A. Paperwork Reduction Act. Section 645.240 in IFR2 also discusses the changes in reporting due to the 1999 Amendments.

The proposed WtW reporting requirements reflect the Department's efforts to strike a balance between minimizing the burden on recipients and subrecipients while obtaining necessary information on the status of funds and program outcomes required by various Federal laws concerned with integrity, accountability, and the measurement of program results.

What Procedures Apply to the Resolution of Findings Arising From Audits, Investigations, Monitoring and Oversight Reviews? (§ 645.250)

We received comments about the liability of the States and local entities. One commenter recommended that the regulations specify local liability for all categories of disallowed costs associated with the funds allocated to the substate areas.

Response: Because the IFR1 did not explicitly address the relationship between grantees and their subgrantees, we have revised § 645.250(a) to indicate clearly that the State or competitive grantee must establish the necessary rules and procedures.

Other comments asked that we clarify that the State is not liable for disallowed costs resulting from local entities' use of competitive grant funds, and suggested that we revise the regulations to require that the State share equitably with the substate entity in any disallowed costs.

Response: Under the regulations as written, a State is not responsible for disallowed costs under WtW competitive grants awarded to local governments, as it is not a party to the grant agreement. Our position on the suggestion that we specify the distribution of liability for disallowed costs as between recipients and subrecipients, and particularly as between States and local governments, is that we do not have the authority to do so without explicit direction in the statute. Accordingly, the suggested changes have not been made.

What Nondiscrimination Protections Apply to Participants in Welfare-to-Work Programs? (§ 645.255)

Section 645.255 provides that participants in WtW programs have such rights as are available under all applicable Federal, State and local laws prohibiting discrimination, and lists four such laws specifically identified in the WtW statute. We received comments from several human rights organizations strongly suggesting that ETA add the Civil Rights Act of 1964 (Title VII) and the Education Amendment of 1972 Title (IX) to the list of statutes in § 645.255(a).

Response: The list in § 645.255(a) contains those laws identified in section 408(d) of the WtW statute, so the suggested statutes could not be added to that section. However, we have reordered the paragraphs in § 645.255 and have explained in a new paragraph (c) that complaints alleging

discrimination in violation of any applicable Federal, State or local laws, such as Titles VII and IX, as well as the Pregnancy Discrimination Act (42 U.S.C. 2000e (paragraph k)), are to be processed in accordance with those laws and their implementing regulations.

A few commenters expressed concern that IFR1 limits WtW participants' protection under gender discrimination laws to ''job readiness and employment activities''.

Response: The WtW statute, at section 403(a)(5)(J)(iii), specifies that participants in ''work activities'' are protected under gender discrimination laws. To be consistent with the language in the law, the Final Rule replaces the phrase ''job readiness and employment activities'' in § 645.255(d) with the phrase ''work activities, as defined in section 407(d) of the Social Security Act.''

In addition, Section 188 of the Workforce Investment Act and its implementing regulations prohibit discrimination on a number of bases, including sex, in all programs and activities, including WtW programs, that are part of the One-Stop delivery system and that are operated by One-Stop partners to the extent that the program activities are being conducted as part of the One-Stop delivery system. The programs and activities covered under these WIA nondiscrimination provisions include those that qualify as ''work activities'' under the WtW statute, as well as the broader range of programs and activities that are offered within the One-Stop system.

We have added new language to the Final Rule in §§ 645.230(i), 645.255, and 645.430, to acknowledge that the DOL regulations implementing WIA section 188, at 29 CFR part 37, are applicable to WtW actvities conducted as part of the One-Stop delivery system. 29 CFR 37.2(a)(2) provides that the WIA nondiscrimination regulations apply to ''[p]rograms and activities that are part of the One-Stop delivery system and that are operated by One-Stop partners listed in section 121(b) of WIA, to the extent that the programs and activities are being conducted as part of the One-Stop delivery system.'' Since the WtW program is one of the required One-Stop partners identified in WIA sec. 121(b), part 37 is applicable to WtW activities carried out as part of the One-Stop delivery system. Similarly, under 29 CFR 37.2(a)(3), the employment practices of such WtW One-Stop partner programs are covered by part 37. WtW One-Stop partner programs should be mindful of their responsibilities under 29 CFR part 37. For example, specific requirements relating to outreach and recruitment, sectarian activities, participant data collections and record-keeping, monitoring, and discrimination complaints processing apply to WtW One-Stop partner programs carrying out WtW activities as part of the One-Stop delivery system. We intend to work closely with the Department's Civil Rights Center, to provide guidance so that WtW programs can meet their responsibilities under part 37.

What Safeguards are There to Ensure that Participants in Welfare to Work Employment Activities do not Displace Other Employees? (§ 645.265)

A comment expressed concern about the interpretation of ''employment activity,'' in the first sentence of § 645.265(b), as it pertains to the prohibition on the use of WtW funds in violation of existing contracts for services or collective bargaining agreements, and recommended that we indicate which elements of § 645.220 would constitute employment activities for purposes of the non-displacement requirement.

Response: We recognize that IFR1 may be unclear about which employment activities are covered under § 645.220. Therefore, we have added a cross reference to § 645.220(b) and (c) in the first sentence of § 645.265 to more clearly indicate what is meant by ''employment activities.'' These activities are as follows: vocational educational and job training, community service programs, work experience programs, job creation through public or private sector employment wage subsidies, and on-the-job training.

One commenter urged that we specify the amount of time that an employer must wait before filling a position that became available due to a lay-off.

Response: Upon review, we believe that it is not appropriate for us to set a minimum waiting period. In our view, individual States and localities should be accorded the discretion to take their particular circumstances into account.

What Procedures are There to Ensure that Currently Employed Workers May File Grievances Regarding Displacement and that Welfare-to-Work Participants in Employment Activities May File Grievances Regarding Displacement, Health and Safety Standards and Gender Discrimination? (§ 645.270)

A number of comments from union and labor management organizations stated that the regulatory procedures for establishing and maintaining grievance procedures are either overly prescriptive or too broadly defined.

Response: We have written the regulations governing grievance procedures to precisely reflect the language of the Act at section 403(a)(5)(J)(iv), while seeking to make the complaint filing system sufficiently clear and to provide State and local governments with the maximum flexibility to establish grievance procedures that adequately address State and local needs. Therefore, no changes have been made in the Final Rule. However, we have added a new section (i) to provide that participants alleging discrimination by WtW programs that are part of the One-Stop system may file a complaint using the procedures developed by the State under the WIA nondiscrimination regulations at 29CFR 37.70–37.80.

Subpart C—Additional Formula Grant Administrative Standards and Procedures

What Constitutes an Allowable Match? (§ 645.300)

Several commenters opined that the match provisions were overly burdensome and impeded program implementation, and requested more flexibility to meet the match requirement with non-cash funds.

Response: While the amount of the required match is statutory, we have provided flexibility by changing the 50 percent limit in § 645.300(b)(3), to allow up to 75 percent of matching funds to be third party in-kind match. At least 25 percent of matching funds must be cash match.

Several commenters recommended expanding the universe of resources that can qualify as match. Some commenters suggested that capital costs, donated property, and funds spent on renovation of existing facilities be considered allowable match.

Response: The Balanced Budget Act of 1997 established WtW as a short-term program. Resources which would be expected to outlast the WtW program, such as those mentioned above, therefore, are not allowable WtW program costs and are not acceptable as match. We have not made the suggested change. However, under the regulations as written, depreciation or use allowances which reflect the use or consumption of capital assets during a reporting period are allowable WtW costs and allowable as match.

Matching funds must be spent on WtW allowable activities for WtW eligible individuals, whether or not the individuals are actually enrolled in a WtW program. Some commenters opined that in their view this definition was overly restrictive and suggested that

any funds spent on training, support or assistance for any individuals should be permitted as allowable match. Other commenters suggested that we permit in-kind contributions, employer-paid wages or employer-paid benefits as allowable match.

Response: Because the purpose of the WtW program is targeted to a specific population and has the specific goal of moving welfare recipients and certain noncustodial parents into unsubsidized employment, matching funds must support the overall design of the program. The purpose of the matching requirement is to leverage these targeted Federal funds and expand services to this population. Thus, while the individuals served with matching funds need not be enrolled in the WtW program, we believe it is important that only funds spent on individuals within the WtW target populations are counted toward the matching requirement. Likewise, we do not believe it is appropriate to eliminate the prohibition in § 645.300(c)(1) on using the employer share of participant wage payments, because it also is intended to ensure that matching funds are spent on expanded services that might not otherwise be provided. On the other hand, as discussed above, we have increased the limit on third-party in-kind contributions to 75 percent. As discussed in Section III of the preamble, the eligibility criteria for the program have been simplified. Any non-Federal dollars spent on the activities identified in § 645.220 for individuals in the new eligible population would count as match. In addition, any excess of funds spent to meet TANF maintenance-of-effort would count as match. We believe that States will now have sufficient flexibility to meet their matching requirement in a manner that will effectively serve the needs of the target population.

A number of commenters have inquired whether Community Development Block Grant funds may be used as match.

Response: As the underlying statute at sections 403(a)(5)(A)(i)(I) and 409(a)(7)(B)(iv)(I) and (IV) does not allow other Federal funds to be used as match, these funds are not an allowable source of match funds. No change to this provision is warranted.

Paragraph 645.300(e)(2) mandates that third-party donations of equipment or space be valued at the fair rental rate. One commenter noted that in certain cases this rule may conflict with OMB Circular A–87, which allows space donated by governmental third parties to be charged based on a use allowance.

Response: The provision has been modified to clarify the distinction between valuation of equipment and space donated by a governmental third party from that donated by a non-governmental third party.

What Actions are to be Taken if a State Fails to Make the Required Matching Expenditures? (§ 645.315)

Section 645.315 provided that we would implement an annual reconciliation of match expenditures and, if necessary, adjust those grants for which the match requirement has not been met. On November 13, 1997, a technical amendment affecting the expenditure of matching funds became law as part of the Labor, Health and Human Services and Education Appropriations Act (Pub. L. 105–78). As requested by comments, the technical amendment changed the period of expenditure for matching funds from one year to three years. States may now spend matching funds over the course of the same three-year period during which they spend the Federal WtW funds. The technical amendment became law immediately after the publication of the November 18, 1997 IFR1 and we received many comments asking that we change the expenditure period from one to three years and pointing out that the regulation had been superseded by the technical amendment.

Response: As a result of this technical amendment, § 645.315, which provided for annual reconciliation and grant adjustment, is superfluous. We have deleted the provision at § 645.315(a). Section 645.315(b) has been revised and redesignated as § 645.315(a) to describe the process that will be followed if a State fails to meet its match requirements at the end of the three-year expenditure period. We have added a new § 645.315(b) to clarify the impact on the administrative cost limit of any failure to satisfy the match requirements.

When Will Formula Funds be Reallotted and What Reallotment Procedures will the Secretary Use? (§ 645.320)

Section 645.320 described the circumstances under which we would reallocate formula funds. Funds that were subject to reallocation included those formula funds returned to the Department after a State had under-expended matching funds within a fiscal year, or had failed to fully obligate formula funds. Some commenters noted that under the technical amendment (Pub. L. 105–78) described above in the discussion of § 645.315, States may now expend required matching funds over a three-year period. In addition, another technical amendment was enacted on October 28, 1998, (Pub. L. 105–306) which altered the obligation requirement for States. Under this amendment, States are not required to obligate certain funds within the fiscal year of appropriation. Under SSA section 403(a)(5)(A)(iv)(II), these funds are the 15 percent funds reserved for the Governor's special projects and the funds allocated within single SDA States.

Response: As a result of the technical amendments identified by the commenters, we will not reallocate any formula funds during the course of the program. Therefore, § 645.320 is no longer relevant and has been deleted.

Subpart D—State Formula Grants Administration

Under What Conditions May the Governor Request a Waiver to Designate an Alternate Local Administering Agency? (§ 645.400)

Waiver Authority. Some commenters stated that the case-by-case review process established by the IFR1 was inflexible, cumbersome, and fraught with delay. The commenters proposed that we modify the system to allow approval of waivers on a statewide basis.

Response: The case-by-case approach is prescribed by the statute at section 403(a)(5)(A)(vii)(III), so the suggested change has not been made. Furthermore, we have determined that, while perhaps somewhat burdensome, the mandated process has functioned adequately.

What Elements Will the State Use in Distributing Funds Within the State? (§ 645.410)

Many comments opposed the § 645.410(a)(7) requirement that a State distribute its SDAs' allocations within thirty days after the State's allotment was received. These comments suggested that the thirty-day deadline for distribution curtailed the States' ability to achieve coordination with local level plans and reduced the States' ability to ensure optimal utilization of funds.

Response: We agree that the 30-day deadline may be overly restrictive and could compromise the States' ability to distribute the funds in an efficient and equitable manner. However, since all of the FY 1998 and FY 1999 formula funds authorized have now been distributed to the local level, such a change would be moot. Therefore, we have made no change in this provision. Further, because all funds have been distributed in a timely manner, we will not be

retroactively looking into whether the 30 day requirement had been met.

What Factors will be Used in Measuring State Performance? (§ 645.420)

Section 645.220(a) provides that we will issue a performance measurement formula following consultation with DHHS, the National Governors Association and the American Public Welfare Association. We have completed the necessary consultation process and received approval of the performance measures from OMB. The Performance Bonus Criteria were published in the **Federal Register** at 63 FR 64832 (Nov. 23, 1998). The formula and data elements used for measuring State performance are included on the OMB-approved *WtW Formula Cumulative Quarterly Financial Status Report* (ETA 9068). Section 645.420(a) is revised to specify that job placement (job entry rate), retention in employment and earnings gain are the elements that will be used to measure performance.

Section 645.420(b) is revised to identify the weights to be accorded the factors included in the performance bonus formula. The formula is based on four factors: (1) Job entry rate as measured by the proportion of WtW participants who enter either subsidized employment or unsubsidized employment; (2) Substantive job entry rate as measured by the proportion of WtW participants who are placed in or who have moved into subsidized or unsubsidized employment of 30 hours or more per week; (3) Retention as measured by the proportion of WtW participants who remain in unsubsidized employment six months after initial placement; and (4) Measured earnings gains of WtW participants who remain in unsubsidized employment six months after initial placement.

How Does the Welfare-to-Work Program Relate to the One-Stop Delivery System and Workforce Investment Act (WIA) Programs? (§ 645.430)

We received several comments about One-Stop systems. Generally, they pointed out the need to address the role of the WtW program in the new One-Stop delivery system initiated under JTPA, and now being implemented under WIA. Specifically, one commenter suggested that intake, assessment, eligibility determination and development of an Individual Service Strategy should be part of the One-Stop system.

Response: The advent of WIA resulted in the inclusion of the WtW program in the One-Stop delivery system as a required partner, and the transition from PIC's to local workforce boards. As discussed above, in relation to § 645.220, we agree with the comments that close coordination between the WtW program and the One-Stop system will be beneficial to all programs that are partners in the system. While the IFR1 delineated the roles and responsibilities of the State(s) and PIC(s) at § 645.425, and that the WtW roles of State and local entities will be the same under WIA as they have been under JTPA, we agree that it is advisable to also provide acknowledgment and guidance about the interaction of the WtW program with WIA programs and other programs delivered through the One-Stop delivery system. We added a new § 645.430 to foster this coordination. As a required partner in the One-Stop delivery system, the WtW program and the local board will enter into a Memorandum of Understanding that includes provisions relating to the services to be provided through the One Stop system and the methods for referring individuals between the One-Stop and the partner WtW program. We expect that WtW participants will have access to the broad range of services available in the One-Stop system. Individuals eligible for WtW who need skill training may receive that service through the One-Stop system and will also be eligible to receive services under WtW such as child care assistance and transportation assistance while participating in the WIA activity. WIA participants who are also eligible for WtW may be referred to WtW for assistance such as job placement and other services.

Also, paragraph (d) of this section explains that 29 CFR part 37 applies to recipients of WtW financial assistance who operate programs that are part of the One-Stop system established under WIA to the extent that the WtW programs and activities are being conducted as part of the One-Stop delivery system.

Subpart E—Welfare-to-Work Competitive Grants

Who Are Eligible Applicants for Competitive Grants? (§ 645.500)

Several comments suggested changes to the categories of entities eligible to apply for competitive grants. Comments proposed the addition of specific types of entities (*e.g.*) labor unions, women's organizations, area vocational schools and public transit agencies) to the list of entities which can apply as a ''private entity'' in conjunction with a local PIC or political subdivision.

Response: As noted above in the discussion of the definitions at § 645.120, we have added the definition of ''private entity'' contained in the WtW competitive grant SGA. Under this definition, a ''private entity'' is any organization, public or private, which is not a Local Board, PIC or alternate administering agency or a political subdivision of a State. The types of organizations that commenters suggested adding meet this definition and are eligible to apply as private entities. Moreover, § 645.500(a)(3) provides an illustrative list of types of private entities that would include the suggested entities as ''nonprofit organizations'' or as ''other qualified private organizations.'' Therefore, because the suggested entities are eligible to apply for WtW competitive grants under the existing IFR1, we do not believe it is necessary to make any other changes to this section.

What Is the Required Consultation With the Governor? (§ 645.510)

Three comments expressed concern about the State-level consultation process. One commenter stated that States should have the same amount of time for comment on competitive grant proposals as the PIC or political subdivision. One commenter argued that the State and local reviews should be concurrent rather than consecutive. One commenter asserted that the Governor's review was counter-productive.

Response: While the reviews of competitive grant applications at the local level and at the State level serve different purposes, they operate sequentially to further the goals of the competitive grant program. We consider it important that the Governor be aware of any concerns about an application that the local board or PIC may have so that the Governor is able to foster cooperation and coordination of resources at the local level. Furthermore, while we acknowledge that the volume of competitive grant proposals has placed a considerable burden on some States, we do not believe that the burden imposed has compromised the competitive grant program.

III. Summary and Explanation—Interim Final Rule (IFR2)

Substantive Changes Under the Welfare-to-Work and Child Support Amendments of 1999

As a result of the Welfare-to-Work and Child Support Amendments of 1999 (1999 Amendments) (introduced as Title VIII of H.R. 3424, and enacted as part of

the Consolidated Appropriations Act for FY 2000, (Pub. L. 106–113)), we have made significant changes to the regulations implementing the WtW grant program. These changes are implemented as an Interim Final Rule (IFR2), published with the Final Rule discussed in Section II of this preamble. These revisions provide WtW grantees with greater flexibility to serve both long-term welfare recipients and noncustodial parents of low-income children. The effective dates of the changes made by the 1999 Amendments are discussed in new §§ 645.130 and 645.135, which are discussed later in this section of the preamble.

The most significant of these changes removes the requirement that long-term TANF recipients must meet additional barriers to employment in order to be eligible for program services, as described in § 645.212. Also, under the 30 percent provision at § 645.213, as provided by the 1999 Amendments, we have added two new categories of eligible participants: former foster care recipients, and custodial parents with income below the poverty line. Among the regulatory definitions in § 645.120, we have defined ''local workforce investment board'' to include former ''PICs'' and ''alternative administrative agencies'' to cover all possible entities operating the WtW program.

We wish to emphasize that we are implementing the changes resulting from the 1999 Amendments as an Interim Final Rule to afford the opportunity for public comment. The preamble also contains guidance to the WtW system in areas where regulations are not promulgated but clarification may be needed.

We invite public comments on the provisions discussed below:

What Definitions Apply to This Part? (§ 645.120)

As a result of the 1999 Amendments, this section has been amended to include additional definitions of terms, acronyms and phrases where needed. To maintain the program's underlying principle of providing State/local governments with maximum flexibility in designing and implementing program objectives, we generally allow State/local discretion in defining most terms.

However, we believe it is necessary to define the term ''unemployed'' for purposes of determining the eligibility of a noncustodial parent at § 645.212(c)(1). For consistency, we are defining this term as it is defined under Title I of the Workforce Investment Act. Under this definition, the term ''unemployed individual'' means an ''individual who is without a job and who wants and is available for work.'' The determination of whether an individual is without a job must be made in accordance with criteria established by the Bureau of Labor Statistics. Information can be found in the BLS publication, *How the Government Measures Unemployment,* at *http://stats.bls.gov/cps_htgm.htm.*

We have not defined the term ''underemployed,'' which permits the State to define it, in consultation with local entities, including competitive grantees within their jurisdiction. Similarly, States, in consultation with local entities, including competitive grantees within their jurisdiction, may define the term ''having difficulty paying child support obligations.'' In developing this definition, State agencies should also consult with the State or local child support enforcement entity. We discuss the terms ''underemployed'' and ''having difficulty paying child support'' in more detail in the discussion of § 645.212 in this section of the preamble.

Additionally, the phrase ''PIC or alternate administering agency'' has been added after each reference to a local workforce investment board throughout 20 CFR part 645. While local workforce investment boards (local boards) are the presumed administering entities under transition from JTPA to WIA, we believe it is important to recognize the administering role of PIC's in the WtW system. We have included these additional terms to emphasize that entities other than local workforce investment boards may serve as WtW administering agencies and that PIC's may still retain their role as the operating entity until such time as WIA is fully implemented, and in some cases, afterward. In accordance with § 661.300 of WIA, we anticipate that most PIC's will be replaced by local workforce investment boards, for purposes of WtW and WIA.

We have also added a definition of ''IV–D Agency'' to clarify that this means the organizational unit in a State that has responsibility for the plan under title IV–D of the SSA which is child support enforcement. The 1999 Amendments have given such entities a definite role in the development of personal responsibility contracts and other matters relating to noncustodial parents.

What Are the Roles of the State and Local Governmental Partners in the Governance of the WtW Program? (§ 645.125)

As we discussed in the preamble to IFR1 (62 FR 61588, 61589), we have tried to limit WtW regulations to only those instances where they are necessary to clarify or explain how we interpret the statute. IFR1 provided States and local governments with the primary responsibility for developing program and policy guidance for this program. We have tried to maintain this flexibility in the changes we have made under the 1999 Amendments. The WIA regulations were drafted under the same principle and, at 20 CFR 661.120, codify this flexibility by providing authority to States and local governments to establish such policy guidance and interpretations, as long as they are not inconsistent with the statutory and regulatory requirements. For consistency, we added a similar regulation to part 645 to reiterate our intention that States and local governments have this policy-making flexibility in administering the WtW program.

What Are the Effective Dates for Implementation of the Welfare-to-Work Amendments? (§ 645.130)

The 1999 Amendments to the WtW eligibility criteria and allowable activities have staggered effective dates depending on the type of funds (competitive, formula, or Indian and Native American) used to pay for the activities. Section 645.130 explains when the various changes made by the 1999 Amendments and this IFR2 took effect:

- For Indian and Native American (INA) grantees, all of the 1999 Amendments took effect upon enactment of the legislation on November 29, 1999.
- For WtW competitive grants, provisions relating to the new eligibility and allowable activities took effect on January 1, 2000, while the other provisions of the 1999 Amendments were effective upon enactment of the legislation on November 29, 1999.
- For WtW formula grantees, provisions relating to the new eligibility and allowable activities took effect on July 1, 2000, except that expenditures could not be made from State allotments until October 1, 2000, as provided in § 645.135.

What is the Effective Date for Spending Federal Welfare-to-Work Formula Funds on Newly Eligible Participants and Newly Authorized Services? (§ 645.135)

As stated above in the discussion of § 645.130, the changes made under the 1999 Amendments became effective for formula grants on July 1, 2000, except that expenditures could not be made from Federal WtW formula allotments until October 1, 2000. The intent of this provision is to prevent the outlay of

Federal WtW formula funds until the first day of fiscal year 2001. It is not intended to prevent the normal incurrence of unpaid obligations until that date, provided that Federal WtW formula funds were not drawn down to liquidate the obligations until October 1, 2000. Therefore States could not draw down WtW formula funds from the Federal Treasury until that date. During the period of July 1, 2000 to September 30, 2000, States could expend matching funds and incur unpaid obligations within the normal course of business, provided that the timing of those transactions ensure that the draw down of Federal WtW formula funds to liquidate the obligations did not occur until October 1, 2000.

How Must Welfare-to-Work Funds be Spent by the Operating Entity? (§ 645.211)

Before the 1999 Amendments, the WtW statute and IFR1 provided for two categories of eligible individuals, those served under the 70 percent provisions and those served under the 30 percent provisions. Noncustodial parents could qualify under either provision, if they met the appropriate criteria. IFR1 required operating entities to expend at least 70 percent of the grant funds awarded on hard-to-employ individuals enrolled under the ''70 percent provision,'' according to the eligibility criteria at § 645.212 of IFR1, and no more than 30 percent on individuals with characteristics associated with long-term welfare dependence under the criteria at § 645.213 of IFR1.

A practical effect of this requirement was that if an operating entity spent up to 30 percent of its funds on individuals with characteristics associated with long-term welfare dependence, but was only able to spend 69 percent of the total funds (or less) on hard-to-employ individuals under the 70 percent provision, it could be penalized with disallowed costs for failure to expend at least 70 percent of its funds on these hard-to-employ individuals. The costs to be disallowed could be otherwise allowable expenditures for the 30 percent ''other eligibles'' individuals. While it was certainly the intent of Congress to insure that the bulk of WtW grant funds be spent on the hardest-to-serve, we do not believe it intended to unnecessarily penalize grantees by disallowing what otherwise would be legitimate expenditures to help other eligible individuals solely on the basis of the fact that the 70/30 ratio was not met. But because of the language of the original statute, this was a possible result.

The 1999 Amendments divide the WtW eligible population into three groups:

1. Hard-to-employ individuals served under ''general eligibility'' provisions at section 403(a)(5)(C)(ii);

2. A separate category for noncustodial parents at section 403(a)(5)(C)(iii); and

3. Others, including individuals with characteristics of long-term welfare dependence, served under the 30 percent provisions at section 403(a)(5)(C)(iv).

The 1999 Amendments alter the eligibility requirements for hard-to-employ individuals and for noncustodial parents and eliminate language referring to any mandatory expenditure level of 70 percent for these groups. The 1999 Amendments do, however, retain the 30 percent maximum expenditure provision for individuals with the characteristics of long-term welfare dependence at section 403(a)(5)(C)(iv).

Note: For ease of identification, IFR2 refers to the group of individuals served under the 30 percent provision as ''other eligibles,'' at § 645.212, and IFR2 refers to the ''general eligibility and noncustodial parent'' category at § 645.212 as the ''primary'' eligibility category (formerly the 70 percent category).

Since the statute no longer specifies a 70 percent expenditure requirement and says only that no more than 30 percent of grant funds may be spent on individuals served under the ''other eligibles'' category, we interpret it to mean that all other expended funds must be spent on individuals enrolled under the primary ''general eligibility and noncustodial parents'' category.

Thus, an operating entity which does not quite spend all of its grant funds, resulting in an expenditure ratio slightly below 70 percent for the general and noncustodial (primary) population, will still be in compliance with the expenditure requirements as long as its expenditures on the other eligibles does not exceed 30 percent of the total grant funds allotted. An operating entity may in fact spend up to 100 percent of its grant funds to benefit individuals in the general eligibility and noncustodial parents (primary) category, as described in § 645.212, as the provision of ''no more than'' 30 percent of the funds spent on ''other eligibles'' would have been met.

This change in the 1999 Amendments allows operating entities more of an opportunity to achieve the intended goal of targeting the hardest-to-employ individuals in the program by the end of the grant period without unintended punitive consequences. To be in compliance, an operating entity must have spent no more than 30 percent of the funds allotted or awarded on the ''other eligibles'' in § 645.213, even if the operating entity has not expended all of its funds.

We see this change as a move away from an arbitrarily punitive way of assessing compliance towards a more realistic approach that recognizes that overall expenditure rates may have been suppressed by the original WtW eligibility criteria. Operating entities are not absolved of the underlying requirement that spending is to be targeted to the hardest-to-serve primary eligibility category and that poor performance in this area will be cited through routine monitoring and oversight. Such poor performance may lead to sanctions such as termination, reduction in grant amount or other actions warranted by the circumstances as determined by the Grant Officer. Falling short of expenditure goals due to lack of effort in serving the primary eligibles will be viewed far differently from a good faith effort to achieve those goals. This change, coupled with the more flexible eligibility criteria in the 1999 Amendments, should encourage grantees to move ahead on enrollments and expenditures in the remaining years of the program without the previous overcaution and concern about how the original 70 percent expenditure requirement would be applied at the closeout of the grant.

The 30 percent maximum expenditure requirement applies to all WtW funds, i.e., to substate formula funds, Governors' funds for long-term recipients of assistance, and competitive funds. The requirement does not apply to the proportion of WtW participants served; rather, it applies to the percentage of WtW funds expended on the participants in each category of eligibility.

The ''general eligibility and noncustodial parents'' (primary) category may include participants who were originally enrolled as individuals with characteristics of long-term welfare dependence under the 30 percent category and transferred to the ''general eligibility and noncustodial parents'' (primary) category after the effective date of the 1999 Amendments. Operating entities should note that expenditures on these individuals prior to their transfer to the ''general eligibility/noncustodial parents'' (primary) category may not be reported as and will not count as expenditures under the new primary category. We intend to provide more guidance on tracking and reporting expenditures under § 645.212 (primary eligibility) and § 645.213 (''other eligibles'' eligibility)

in revised WtW participant and financial reporting instructions to be issued separately.

Who May Be Served Under the General Eligibility and Noncustodial Parent Eligibility (Primary Eligibility) Provision? (§ 645.212)

As discussed above, under the 1999 Amendments, 30 percent of WtW funds may be spent on individuals served under the ''other eligibles'' category, and the remaining funds must be spent on the ''general eligibility and noncustodial parents'' (primary) category of eligibility. The main purpose of the 1999 Amendments was to simplify the WtW eligibility requirements by eliminating the requirement that long-term TANF recipients or exhaustees demonstrate two of three specified barriers to employment (education level and low skills in reading or math; requires substance abuse treatment for employment; and poor work history). The comments from a variety of public and private entities about these barriers are discussed in detail in Section II of this preamble in the discussion of § 645.212.

General Eligibility. The general eligibility portion of the primary eligibility provision focuses on the target groups expected to constitute the majority of those served in WtW due to their status as TANF recipients. The regulations reflect the statute in describing these target groups as follows:

1. Current TANF recipients who have received TANF assistance for at least 30 months;

2. Current TANF recipients who will become ineligible for TANF assistance within 12 months; or

3. Former TANF recipients who are no longer receiving TANF assistance because they reached the Federal or State-imposed time limit.

As these groups were already included in the groups possibly eligible for the the primary eligibility portion of WtW, the 1999 Amendment's elimination of the barriers to employment requirements should significantly increase the number of participants eligible for the program, without requiring the addition of any verification procedures not already in place.

Noncustodial Parent Eligibility. Under the 1999 Amendments, operating entities now serve noncustodial parents in the WtW program under separate noncustodial parent eligibility criteria, set forth in the primary eligibility provision for general eligibility and noncustodial parents at § 645.212. Most often, noncustodial parents are fathers with minor children who do not live in the same household as the child. To be eligible under this provision, noncustodial parents must meet three criteria (generally, the noncustodial parent must be unemployed, underemployed or having difficulty making child support payments; the minor child must be receiving or be eligible for TANF or other specified assistance; and the noncustodial parent must enter into a personal responsibility contract).

The first requirement is that the noncustodial parent be ''unemployed, underemployed, or having difficulty making child support payments.'' Since the WtW program is a required partner in the workforce investment system established under WIA, we believe it is important to coordinate WtW program definitions or requirements with those set forth under WIA wherever possible or appropriate. Therefore, the definition for ''unemployed'' set forth in the WtW regulations at § 645.120 corresponds to the definition of ''unemployed individual'' in section 101(47) of WIA. This is discussed in more detail above under the discussion of § 645.120 in this section of the preamble. We have not defined the other two terms in this criterion.

We allow the States to determine how to define the term ''underemployed,'' in consultation with local operating entities, including local competitive grantees. We suggest that States consider the definition used in the Indian and Native American WIA program at 20 CFR 668.150, where underemployed means an individual who is working part time but desires full time employment, or who is working in employment not commensurate with the individuals's demonstrated level of educational and/or skill achievement.

States, in consultation with local entities, including competitive grantees within their jurisdiction, and the State Child Support Enforcement (IV-D) Agency, may define what constitutes ''having difficulty paying child support obligations,'' and should coordinate with the State or local child support enforcement entity. For example, a State may decide that if a noncustodial parent is behind in his/her payments as specified in a child support order for one or more months, this constitutes ''having difficulty paying child support obligations,'' as the noncustodial parent is now in arrears. In such cases, the child support enforcement entity would be able to assist in identifying such arrearages. Another example of a definition of ''having difficulty paying child support'' would be any noncustodial parent that has not yet established paternity or who does not have a child support order but is not working and hence, has no ability to pay child support, if ordered.

Effective dates for the implementation of the 1999 Amendments are discussed in this section of the preamble at § 645.130 and § 645.135. However, entities operating competitive grants have expressed concern that there may be a delay before States articulate definitions for these and other terms under the 1999 Amendments, given the later effective date for formula grantees.

States and local workforce investment boards may establish definitions for the WtW program. Competitive grantees are encouraged to provide input in the development of these definitions, as they will be required to follow these definitions once established by the State and local area, as was the case in the establishment of definitions for ''characteristics of long-term welfare dependence'' under IFR1. When terms are not defined by the State or local board in the area in which a competitive grantee operates, competitive grantees may establish their own definitions for ''underemployed'' and ''having difficulty making child support payments.'' However, once State or local board definitions become effective, competitive grantees are required to follow them.

The second requirement for the enrollment of a noncustodial parent in the WtW program relates to the financial status of the minor child (or, in certain cases, the custodial parent). The noncustodial parent may be eligible if the minor child or custodial parent is a long-term TANF recipient. The noncustodial parent may also establish eligibility if the minor child is a current or recent TANF recipient, or is receiving or is eligible for Food Stamps, Supplemental Security Income, Medicaid, or State Children's Health Insurance Program (SCHIP).

Operating entities must first attempt to determine whether a noncustodial parent's child(ren) is actually receiving any of the above benefits by obtaining documentation of such benefits from the custodial parent or by confirmation from the agency that the minor child or custodial parent, for purposes of determining long-term TANF receipt, is receiving services under the program.

It is important to note, however, that the 1999 Amendments explicitly state that in order to protect custodial parents and children at risk of domestic violence, the custodial parent may not be required to cooperate in the establishment of the noncustodial

parent's eligibility based upon the custodial parent's or minor child's receipt of certain benefits and services. The cooperation of the custodial parent is not to be construed as a condition for participation in the program of either parent, as the safety of the custodial parent and/or child takes precedence over the direct gathering of information from a custodial parent when domestic violence or risk of domestic violence is a factor. If a grantee wishing to enroll a noncustodial parent under the above eligibility criterion is not able to verify receipt of benefits and services from the custodial parent due to the risk of domestic violence, the grantee should attempt to get this information from the responsible agency, or should employ the presumptive eligibility determination methods outlined below.

Presumptive Eligibility Determination. We are especially seeking comments on the IFR2's method of determining if a minor child is eligible for assistance under the Food Stamps Act of 1977, benefits under the supplemental security income program under Title XVI (SSI), medical assistance under Title XIX (Medicaid), or child health assistance under title XXI of the Social Security Act (SCHIP). For purposes of this new IFR2, we offer the following method.

In cases where the child or custodial parent is not receiving benefits, or when there is not a timely response from the responsible agency, the State or the operating entity must develop its own reasonable method for determining whether a child is eligible for benefits under any of the above-specified programs. The method devised by the operating entity may include an objective standard to be used as a proxy determination for eligibility for the specified programs. For example, the State may adopt an income test under which an individual or family would be eligible for one or more of these programs for purposes of determining WtW noncustodial parent eligibility.

In general, SCHIP has the simplest eligibility of the four programs, requiring only an income determination. In most States, the SCHIP program is also the most generous program (*i.e.,* it has the highest minimum income level for eligibility purposes), with 30 States providing benefits for children with family incomes up to 200 percent of the poverty guidelines. To determine eligibility for SCHIP, and hence qualification of the noncustodial parent as meeting this portion of the criteria in these States, it makes sense for the State or an operating entity to establish a presumptive eligibility guideline for WtW purposes based on the SCHIP income level for that State since this program likely has the largest group of potentially eligible individuals and families. For those States where SCHIP eligibility is set at a level lower than 200 percent of poverty, or where another of the programs identified may have more generous eligibility criteria, States and operating entities should consider adopting the eligibility criteria which is most generous of the four specified programs as a presumptive eligibility guideline for determining eligibility for noncustodial parents under WtW. The website which discusses State income eligibility limits for SCHIP may be found at *http://www.insurekidsnow.gov/childhealth/states/states.asp.*

Upon determining presumptive eligibility for the WtW program based on any of the relevant programs, operating entities should notify the noncustodial parent or the custodial parent, if the address is known, that his/her children may be eligible for additional services. Determining presumptive eligibility for WtW under this provision does not change the application or eligibility requirements for any other programs. In most programs, only the custodial parent or child's caretaker is able to make application for benefits or services.

Additional Eligibility Requirement for Noncustodial Parents: Personal Responsibility Contracts. The third factor in the eligibility determination process for noncustodial parents under the 1999 Amendments is participation in a personal responsibility contract. This essential element for the enrollment of noncustodial parents is covered in a new section of the regulations. A description of the contents, the parties to the contract, and time frames is contained in a new § 645.215, and is discussed in this section of the preamble under that designation.

Who May Be Served as an Individual in the ''Other Eligibles'' (30 percent) Provision? (§ 645.213)

This section describes the new eligibility criteria for individuals under the 30 percent provision as required by the 1999 Amendments. The new 30 percent criteria retain eligibility for individuals who are receiving TANF assistance and who have characteristics associated with, or predictive of long term welfare dependence, as determined by the State in consultation with the local operating entities. The examples given in IFR1 of school dropout, teenage pregnancy or having a poor work history remain as guidance. The 1999 Amendments also allow local boards to establish criteria for determining if an individual has significant barriers to self-sufficiency.

New provisions in the amendments also add two new groups of eligible individuals to those who may be served under the ''other eligibles'' provisions of § 645.213. These are certain individuals who have been in foster care and custodial parents with incomes below the poverty line.

The provision at § 645.213(c) of IFR1 provided eligibility under the 30 percent provision for individuals with characteristics associated with long-term welfare dependence but who were not TANF recipients because they had reached federal or State-imposed time limits. We have deleted this provision because these individuals can be served under the 70 percent provisions at § 645.212(b) as a result of the 1999 Amendments.

Individuals Who Have Been in Foster Care. Section 645.213(c) provides that an individual who is at least 18 but not yet 25 years of age, who was in foster care before age 18, is eligible for the WtW program under the '''other eligibles'' portion. The 1999 Amendments provide that the individual must have been a recipient of foster care maintenance payments, as defined in section 475(4) of the Social Security Act (42 U.S.C. 675(4)), or was in foster care under the responsibility of the State. This foster care could have occurred in, but is not limited to, family homes, group homes or child care institutions.

Section 475(4) of the Social Security Act contains a definition of ''foster care maintenance payments.'' Section 472 of the Social Security Act describes the Federal Foster Care Maintenance Payments Program itself.

It should be noted that the definition of foster care under the responsibility of the State includes children on whose behalf Federal foster care payments were made. Thus, for WtW eligibility purposes, all individuals under foster care in the State, whether or not State or Federal funds are paid on the individuals' behalf, are considered to have been under the responsibility of the State. For assistance in determining eligibility for WtW, operating entities should contact the appropriate State Child Welfare or Child Protective Services Agency to verify whether, in fact, an individual was in its foster care system.

Recruiting Youth Who Have Been in Foster Care. We suggest that operating entities contact their State's Independent Living Coordinator to ensure that former foster care individuals who meet the eligibility requirement are referred to WtW

programs. Grantees can find the Independent Living Coordinator in their area by calling their State Department of Health and Human Services.

Custodial Parents With Incomes Below the Poverty Line. A new category of eligible WtW participants under the ''other eligibles'' provision is custodial parents with incomes below the poverty line. Receipt of TANF or other public assistance is not a requirement for eligibility under this provision. To ensure consistency with other Federal programs and among States, § 645.213(c)(1) provides that operating entities must use the most recent DHHS Poverty Guidelines to determine whether an individual's income is below the poverty line. The Guidelines are updated annually, as required by section 673(2) of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97–35). The 1999 DHHS Poverty Guidelines are available in the **Federal Register**, at 64 FR 13428–13430 (Mar. 18, 1999), or on the following website: *http://aspe.hhs.gov/poverty/00poverty.htm.*

Determination of Income. To determine whether an individual's income is below the poverty line, § 645.213(c) provides a method that is based upon the WIA method for determining income under the definition of ''low income individual,'' at WIA section 101(25). This method entails utilizing total family income for the last six months with exclusions for unemployment compensation, child support payments, cash payments under a Federal, State or local income-based public assistance program, and old-age, survivors benefits received under section 202 of the Social Security Act (42 U.S.C. 402), and other amounts specifically excluded by any other Federal statute for consideration as income.

Allowing each State to determine income could lead to many variations on what is considered income as there are a variety of income requirements among the various entitlement programs such as Food Stamps and Medicaid. There are also variations within the same programs from one State to another. The WIA-based method adapted here would provide consistency among operating entities while fulfilling the intent of serving low income custodial parents.

Receipt of cash payments for a Federal, State, or local income-based public assistance program might be an acceptable indication that an individual's income is below the poverty line for purposes of meeting the eligibility criteria in § 645.213(c)(1). However, it is acknowledged that some States benefits and services are provided to individuals and families whose income may be above the poverty line. If the operating entity is able to confirm that receipt of a particular kind of assistance is limited to individuals with incomes below the poverty line, receipt of assistance from that program would be an acceptable proxy for income below the poverty line. If the program used as a proxy income test also serves individuals or families with incomes above the poverty line, then operating entities must take care to determine that individuals served with WtW funds meet the income test of § 645.213(c)(1). For programs limited to individuals or families below the poverty line, documented receipt of assistance will suffice for purposes of complying with § 645.213(c)(1).

Finally, as provided in WIA low income guidelines, a custodial parent with a disability whose own income includes receipt of cash payments under a Federal, State or local income-based public assistance program, or whose own income for the prior six month period with the exclusions discussed above, does not exceed the poverty line would be eligible under this provision. The disabled individual may be a member of a family whose income does not meet these requirements. The overall consistency with WIA's definition of ''low-income individual'' should enhance the partnership at the local level required between WtW and WIA.

How Will Welfare-to-Work Participant Eligibility Be Determined? (§ 645.214)

Section 645.214 has been revised to reflect the 1999 Amendments' addition of new groups of eligible individuals, and its removal of the barriers to employment formerly required under § 645.212(a)(2). As amended, the IFR2 requires that operating entities have mechanisms in place to determine the eligibility of all participants. It is especially important that operating entities have effective mechanisms in place to determine the eligibility of noncustodial parents as well as individuals formerly in foster care, because these groups have not traditionally been closely attached to the TANF system. As described above, this section provides States and operating entities with authority to use a presumptive eligibility determination procedure for purposes of noncustodial parent eligibility under § 645.212(c)(2)(iii), when WtW eligibility is based upon the minor child's eligibility for other programs.

What Must a WtW Operating Entity That Serves Noncustodial Parents Do? (§ 645.215)

Preference. According to the 1999 Amendments, among all eligible noncustodial parents, preference for admission must be given to those noncustodial parents of minor children who are, or whose custodial parents are, long-term TANF recipients (i.e., received TANF for at least 30 months or will become ineligible for TANF within 12 months due to time limits). However, these noncustodial parents eligible under § 645.212(c)(2)(i) do not have preference over all other categories of eligible participants, just over other noncustodial parents.

In order to satisfy this requirement for preference to noncustodial parents of minor children who are, or whose custodial parents are, long-term recipients of TANF, § 645.214 requires that operating entities must create a mechanism to implement this preference. However, in creating this mechanism to establish preference for these noncustodial parents, we would like to make clear that this does not mean that this category of eligible noncustodial parents must be exhausted before any other category of eligible noncustodial parents may be served. The operating entity may establish a process that gives preference to noncustodial parents eligible under § 645.212(c)(2)(i) and that also provides services to noncustodial parents eligible under the other provisions of § 645.212(c)(2).

Personal Responsibility Contracts. The WtW operating entity must ensure the fulfillment of the personal responsibility contract provision of section 403(a)(5)(C)(iii)(III) of the Act. Section 645.215(c) requires that noncustodial parents participating in a Welfare-to-Work program must comply with the terms of a personal responsibility contract as a condition of their eligibility and continued participation in the WtW program. The parties to the contract are (1) the noncustodial parent, (2) the entity operating the WtW program and (3) the agency responsible for administering the State child support enforcement plan under title IV, part D of the Social Security Act (IV–D agency, or Child Support Enforcement agency). In drawing up the personal responsibility contract, the parties must take into consideration the employment and child support status of the noncustodial parent.

The State IV–D agency has an important role in establishing personal responsibility contracts, because these

contracts involve matters relating to paternity (if the participant is male), establishing and monitoring child support orders, and modification of such orders as program participation warrants. Section 645.215(c)(2) requires that the State IV–D agency be a party to the personal responsibility contract. We expect that the WtW operating entity and the IV–D agency will develop a working relationship at the local level so that personal responsibility contracts are executed in a timely fashion. However, the Secretary may permit the WtW operating entity to enter into a personal responsibility contract with a noncustodial parent, without the State IV–D agency as a party to that contract, if the operating entity demonstrates, through written documentation, that it is not able to coordinate with the IV–D agency. We expect that this will be a rare occurrence, and will issue guidance on how to demonstrate this in the future.

Content of the Personal Responsibility Contract. Section 645.215(c)(3) requires that the personal responsibility contract contain certain specified elements. The first required element is a commitment by the noncustodial parent to cooperate, at the earliest opportunity, in the establishment of the paternity of the minor child (if the participant is male). Paternity may be established through voluntary acknowledgment or through other procedures that may be pursued by the WtW operating entity and/or the State IV–D agency. The noncustodial parent must commit to cooperate with the State IV–D agency in establishing a child support order, if one is not already in place.

It is very important to remember that the cooperation of the custodial parent must not be required as a condition of the noncustodial parent's eligibility. The 1999 Amendments expressly state that in order to protect custodial parents and children at risk of domestic violence, the custodial parent may not be required to cooperate in the establishment of paternity or establishing and enforcing a support order with regard to a child. The cooperation of the custodial parent is not a condition for participation in the program of either parent, as the safety of the custodial parent and/or child takes precedence over the establishment of paternity when domestic violence or the risk of domestic violence is a factor. However, because voluntary paternity establishment can only be accomplished with the consent and signatures of both parents, issues of how to approach custodial parents should be part of the consultation that WtW programs have with domestic violence organizations (see discussion below in this section).

The second required element in the personal responsibility contract is the noncustodial parent's commitment to cooperate in the payment of child support for the minor child. The parties should take into consideration the ability of the parent to pay the child support during participation in the WtW program. The IV–D agency might be able to provide flexibility within their State guidelines on the payment of child support such as the establishment or modification of a child support order while noncustodial parents are participating in the program, suspension or reduction in the order, suspension of interest accruing on arrears, suspension of enforcement actions, such as driver's license suspension; and compromise of child support debt owed to the State.

The third required element in the personal responsibility contract is a commitment from the noncustodial parent to participate in the WtW program in order to meet these child support obligations. We expect that the noncustodial parents will generally be engaged in employment or work-related activities that provide income at a level that will allow these obligations to be met in a timely fashion to benefit the minor child. If a noncustodial parent is less than 20 years of age, the individual may engage in activities that relate to obtaining a high school diploma or a general equivalency degree, or other education directly related to employment. Because of the overall intent to engage noncustodial parents in the provision of monetary support to a child, this other pre-employment education must be directly related to employment and should not exceed six months in duration. This time limit is consistent with the time limit on vocational educational training and job training which occur prior to employment as provided in § 645.220 of the IFR2, which is described below in this section of the preamble. Education directly related to obtaining a high school diploma or a general equivalency degree has no specific time limit but the duration of participation should be estimated and monitored by the operating entity.

The fourth required element in the personal responsibility contract is a description of the services to be provided by the WtW program to the noncustodial parent which are designed to assist the noncustodial parent to obtain and retain employment and increase his or her earnings to enhance his or her financial and emotional contributions to the well-being of the child.

Documentation of the Personal Responsibility contract. Section 645.212(c)(3) provides that the personal responsibility contract may be either an oral or written agreement. We believe it is in the best interest of all parties that the agreed-upon terms of the personal responsibility contract be clearly described in a written document. However, if all the required parties choose to enter into an oral personal responsibility contact, meeting all the required conditions, we strongly encourage WtW operating entities to document the oral personal responsibility contract so that there is a record of what agreements the parties reached. An example of such documentation would be a notation in the participant's file noting the date the oral contract was made, the parties to the contract, and the terms of the contract. We also strongly recommend that the noncustodial parent be given a copy of the documentation or a letter summarizing the terms agreed upon for the sake of consistency in following up on the oral contract during the period of enrollment in the program.

Timeframe for the Establishment of Personal Responsibility Contracts. Under § 645.215(c)(4), the parties must enter into a personal responsibility contract no later than 30 days after the noncustodial parent enrolls in a WtW program and is receiving services through a Federally funded WtW project. When there is good cause, the operating entity has the option of extending this time period to no later than 90 days for itself or its subrecipients. The entity has the discretion to grant such an extension on an individual or a broader basis. It is up to the operating entity to decide what is good cause for the extension. For example, the entity may require a showing of a particular reason why more than 30 days is needed in individual cases, or may determine that more than 30 days is generally needed and grant an across-the-board extension.

Pre-existing Personal Responsibility Contracts. For participants for whom similar personal responsibility agreements already exist, these pre-existing agreements may be used for WtW purposes, as long as they contain the elements described in § 645.215(c). Therefore, any pre-existing agreements may be adapted to incorporate a commitment on the part of the noncustodial parent to cooperate in establishing paternity (if male), paying child support, and participating in WtW services designed increase his/her employment and earnings if it does not already contain these elements.

Domestic Violence Consultation. WtW entities that operate a program serving noncustodial parents under the new noncustodial parent eligibility criteria in § 645.212(c) must take certain precautions when determining eligibility for the program and establishing personal responsibility contracts with noncustodial parents. As described above, the statute explicitly states that, to protect custodial parents and children at risk of domestic violence, the custodial parent cannot be required to cooperate in the establishment of paternity or establishing and enforcing a support order with regard to a child. To assist the WtW operating entity with developing such precautions, § 645.215(b) requires that it must consult with domestic violence prevention and intervention organizations before operating a project to serve noncustodial parents under § 645.212(c). This consultation is intended to raise the awareness of operating entities about the issues associated with domestic violence, and to provide operating entities with the practical knowledge and resources needed to safely and effectively address domestic violence issues as they arise in programs where noncustodial parents are served.

Operating entities who have been serving noncustodial parents in their WtW programs prior to the passage of the 1999 Amendments are strongly encouraged to amend their operating procedures to include regular and continuing consultation with domestic violence organizations regarding their services to these individuals. This consultation is mandatory if the operating entity wishes to continue to enroll noncustodial parents under the criteria set forth in this IFR2.

Domestic violence information, including assessment and intervention resources, hotline and referral telephone numbers, confidentiality protections information, legal, supportive services, and safety planning resources; and contact information for domestic violence organizations, will be posted on the WtW web site shortly (*http://wtw.doleta.gov*). Operating entities may use this information to locate domestic violence organizations in their areas and fulfill the consultation requirement. We urge WtW operating entities to use these resources to help meet the consultation requirement and to ensure that their programs fully address domestic violence issues and concerns in the context of the provision of services to noncustodial parents, and the provision of services to custodial parents and children at risk for domestic violence.

What Activities are Allowable Under this Part? (§ 645.220)

As provided in the 1999 Amendments, new § 645.220(b) adds short-term vocational educational training and job training to the list of allowable WtW activities. Under this provision, operating entities may provide these activities before the participant enters into employment or a WtW employment activity (as specified in § 645.220(c), formerly § 645.220(b)). These training activities have been allowed as post-employment services since the inception of the WtW program. We have not defined the terms ''vocational educational training'' and ''job training,'' to permit the States and competitive grantees to define them. However, under any such definition, these activities must be related to preparing a participant for employment. Therefore, for example, English-as-a-Second Language training must be directly tied to the needs of the workplace, such as by teaching the terms a participant will need for a particular job, in order to be allowable vocational educational training.

A participant may only receive up to six calendar months of vocational educational training or job training prior to entering employment or beginning a WtW employment activity. The six month period begins on the date the participant enters a training activity and must end no later than six calendar months from the beginning date, unless the participant enters into employment or a WtW employment activity before the conclusion of the six month period. In that case, the six month ''clock'' stops. If a participant leaves the employment activity or ceases to be employed, the participant could again enroll in vocational educational training or job training. Re-enrollment restarts the ''clock'' and is available for the time remaining in the six month period. In no case may a participant receive, in aggregate, greater than six months of pre-employment vocational educational training or job training.

Although vocational education and job training are new additions to the list of allowable activities, these activities may, in some cases, be the same as those provided by an operating entity as post-employment services to participants who are employed or participating in a WtW employment activity. The important distinction is that no time limit applies to any type of vocational educational training or job training when the participant is employed or engaged in an employment activity, as described in § 645.220(c).

For What Activities Must Local Workforce Investment Boards and PICs Use Contracts or Vouchers? (§ 645.221)

When enacted in 1997, the WtW statute required that all WtW operating entities, both competitive and formula, provide job readiness, job placement and post-employment activities through job vouchers or through contracts with public or private providers. This requirement anticipated the subsequent passage of the WIA by generally putting PIC's into the role of oversight, planning and policy direction as opposed to program operations. Under WIA, PIC's will be replaced by local workforce investment boards. Unlike PIC's under JTPA, local workforce investment boards generally may not directly provide WIA services. The Balanced Budget Act's attempt to anticipate WIA had several unintended consequences.

Although PIC's were the presumed local operating entities under the WtW formula grant program, they have not been in all cases. In addition, most WtW competitive grantees are not PIC's. WtW competitive grantees are mostly local community-based public or private organizations with special capabilities, innovations or partnerships that allow them to operate an effective program at the community level. By prohibiting *all* WtW grantees from directly providing job readiness, job placement, and post-employment services in order to anticipate a changing local board role under WIA, the WtW statute unintentionally restricts community-based organization grantees from providing direct services which they are uniquely qualified to deliver.

The 1999 Amendments correct this unintended consequence by allowing WtW operating entities that are not PIC's or local workforce investment boards to provide services directly, including the previously limited job readiness, job placement, and post-employment services.

Prior to the passage of the 1999 Amendments, we issued a Q and A in Training and Employment Guidance Letter (TEGL) No. 5–98 in an attempt to clarify this issue. In TEGL 5–98, we said that a WtW operating entity may not directly operate a program to provide job readiness, job placement or post-employment services. However, a WtW operating entity may directly operate a work experience program, a community service program or an on-the-job training program. TEGL 5–98 states that where job readiness, job placement or post-employment services are a reasonable and necessary component of the operating entity's work experience program, a community service program

or an on-the-job training program, then the operating entity could provide those services as part of the overall program. We have found that this guidance was widely misinterpreted in the field, and that many operating entities may have provided direct services where the circumstances would not have allowed this under the narrow circumstances permitted under TEGL 5–98. We now recognize that our guidance was not clear enough to ensure all grantees were in conformity with the contract/voucher requirement.

The 1999 Amendments have now corrected the unintended consequence of applying the contract/voucher requirement to all operating entities, by specifically permitting all WtW operating entities that are not PICs or local boards to directly provide job readiness, job placement and post-employment services. We do not intend to penalize operating entities which may have previously violated the contract/voucher requirement while relying in good faith on guidance promulgated by the Department that was open to misinterpretation. However, we do intend to ensure that operating entities that are PIC's or local boards conform with the contract/voucher requirement. Towards that end, we have added a new § 645.221 to clarify how the contract/voucher requirement applies to PIC's and local boards and other operating entities, and to provide a grace period for entities that may have violated this requirement in reliance on our guidance. Section 645.221(b) provides that all PIC's and local boards operating WtW programs must come into compliance with the contracts and vouchers requirements in this section by February 12, 2001.

What are the Reporting Requirements for Welfare-to-Work Programs? (§ 645.240)

The WtW Amendments of 1999 eliminated the reporting requirements for WtW formula grants found at section 411(a)(1)(A) and amended section 403(a)(5)(C) of the Act to grant responsibility for simplified WtW State formula and competitive grant financial and participant data collection and reporting to the Secretary of Labor, in consultation with the Secretary of Health and Human Services, States, and organizations that represent State or local governments.

The previous participant data collection and reporting requirements mandated that States collect on a monthly basis, and report to the Department of Health and Human Services on a quarterly basis, numerous disaggregated case record data on individuals who were receiving assistance under a State TANF program, and who were also participating in a WtW program. The Secretary of Labor was responsible for establishing participant data collection and reporting requirements for WtW competitive grant recipients and for establishing financial reporting requirements.

Under the 1999 Amendments, the Secretary of Labor will establish requirements for the collection and maintenance of financial and participant information and the reporting of that information by WtW State formula grants and WtW competitive grantees. Section 645.240 has been revised to reflect the Secretary's authority to establish these reporting requirements.

What Factors Will Be Used in Measuring State Performance? (§ 645.420)

As originally enacted in section 403(a)(5)(E) of the Act, $100 million was set aside from FY 1999 funds to provide a performance bonus to successful States. This bonus award was to be made in FY 2000. The 1999 Amendments reduced the amount available for performance bonuses to $50 million, and require that no outlays of these funds occur before October 1, 2000 (FY 2001). As discussed in Section I of this preamble, we have revised § 645.420 to reflect the criteria that will used to award performance bonuses to successfully performing States. Additionally, we have amended paragraph (c) of this section to indicate that bonus awards will not be made until FY 2001.

Under What Circumstances May States Disclose Information to Aid Administration of Welfare-to-Work Grant Funds? The 1999 Amendments made several changes to existing information disclosure requirements, in order to assist the WtW system in serving noncustodial parents. The 1999 Amendments amended sections 403(a)(5) and 454A(f) of the Act to authorize State IV–D agencies and State TANF agencies to share certain information on noncustodial parents with local workforce investment boards or PIC's for the purpose of identifying and contacting the individuals about participation in the WtW program. The State agencies may share the names, addresses, telephone numbers and identifying case number information of noncustodial parents residing in the local area/service delivery area of the local board or PIC. The information can only be shared with local boards or PICs operating WtW programs. The State IV–D agencies and State TANF agencies disclosing this information must ensure that the recipients of this information have procedures in place for safeguarding the privacy of the information and for ensuring that the information will be used solely for WtW recruiting purposes.

We recognize the need for guidance about information sharing under the 1999 Amendments, and about the safeguards needed for protecting that information. We do not, however, intend to issue regulations on this subject, since the ultimate responsibility for ensuring that States safeguard this information lies with DHHS. Instead, we consulted with DHHS, and intend to issue information and guidance on the applicable requirements in the future, and expect that the specific safeguards to be established will be left up to each State.

In May, 2000 we distributed TEGL No. 11–99 which provides ''Joint Guidance on Strategies to Enhance the Recruitment, Referral, Eligibility Determination, and Service Provision Processes Between Welfare-to-Work, Temporary Assistance for Needy Families, and Child Support Enforcement Entities.'' This was a product of earlier collaboration between the Department and DHHS to improve WtW program operations by presenting strategies and suggestions on cross-cutting issues including the sharing of information on noncustodial parents. This document can be found at *http:wtw.doleta.gov/11–99at.htm.*

IV. Administrative Information

A. Paperwork Reduction Act

Information collection requirements are contained in this rule at § 645.240. As required by the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)), the Department submitted pertinent reporting documents and justification separately to OMB at the time IFR1 was published. OMB has assigned Control Number 1205–0385 to the Welfare-to-Work Formula (ETA 9068) and Competitive (ETA 9068–1) Cumulative Quarterly Financial Status Reports.

Because the 1999 Amendments called for the Department to simplify reporting requirements and to collect participant data, we have revised the existing reporting formats and instructions for competitive and formula grantees, in consultation with DHHS and State and local government representatives. On August 22, 2000, we published a Notice in the **Federal Register** inviting public comment on the proposed information collection package. After the comment period, we will submit this revised

information collection to OMB for approval. Therefore, the information collection requirements associated with this rulemaking will not become effective until approved by OMB.

B. Executive Order 13132 (Federalism)

ETA has reviewed this rule in accordance with Executive Order 13132 regarding Federalism, and has determined that it does not have ''federalism implications.'' While this rulemaking was begun prior to the issuance of Executive Order 13132, we have attempted to provide States with the maximum administrative discretion possible. As described in the preamble to IFR1, we have conducted extensive consultations with State and local governmental officials in the development of IFR1, and this Final Rule.

Shortly after enactment of the 1999 Amendments, the Department consulted with public interest groups and intergovernmental groups on the development of regulations necessary to implement the 1999 Amendments. Included in the consultation process were representatives of the National Association of Counties, the Conference of Mayors, the National Governors' Association, and the Interstate Conference of Employment Security Agencies.

C. Regulatory Flexibility and Regulatory Impact Analysis, SBREFA; Family Well-being

The Regulatory Flexibility Act (5 U.S.C. Chapter 6) requires the Federal government to anticipate and reduce the impact of rules and paperwork requirements on small businesses and other small entities. ''Small entities'' are defined as small businesses (those with fewer than 500 employees, except where otherwise provided), small non-profit organizations (those with fewer than 500 employees, except where otherwise provided) and small governmental entities (those in areas with fewer than 50,000 residents). This rule will affect primarily the 50 States, the District of Columbia, and certain Territories. As described in the preamble to IFR1, ETA has taken a variety of measures to minimize any potential burdens for grant applicants and recipients in order to maximize the resources available to achieve the purposes of the WtW program. The Department has assessed the potential impact of the Final Rule and IFR2, consulting with a wide range of small entities, in order to identify any areas of concern. Therefore, based on that assessment, the Department certifies that these Rules, as promulgated, will not have a significant impact on a substantial number of small entities.

In addition, under the Small Business Regulatory Fairness Act (SBREFA) (5 U.S.C. Chapter 8), the Department has determined that these are not ''major rules'', as defined in 5 U.S.C. 804(2). The Department certifies that the Final Rule and IFR2 have been assessed in accordance with Pub. L. 105–277, 112 Stat. 2681, for their effect on family well-being. The purpose of the WtW program is to provide job opportunities and support and job retention services to current or former TANF recipients, low income custodial parents, noncustodial parents and other eligible individuals so that they may attain economic self-sufficiency. Programs are designed at the State and local level to fulfill this purpose with the effect of enhancing family well-being through increased earnings and increased ability for noncustodial parents to pay child support.

D. Executive Order 12866

Executive Order 12866 requires that regulations be drafted to ensure that they are consistent with the priorities and principles set forth in the Executive Order. We have determined that these rules are consistent with these priorities and principles. This rulemaking implements statutory authority based on broad consultation and coordination. It reflects our response to comments received on IFR1 that we issued on November 18, 1997.

The Executive Order encourages agencies, as appropriate, to provide the public with meaningful participation in the regulatory process. We consulted with the Departments of Health and Human Services, Housing and Urban Development, and Transportation, and with other responsible agencies as well as with State and local officials and their representative organizations, in addition to a broad range of advocacy groups and others to obtain their views prior to the publication of IFR2. We also considered comments received in response to IFR1. We have responded to the comments received in the ''Background'' and the ''Summary and Explanation'' sections of the preamble.

To a considerable degree, these rules reflect the comments that we received in response to IFR1. They also reflect the intent of the Act to move hard-to-employ welfare recipients and certain noncustodial parents into unsubsidized employment and economic self-sufficiency. We have determined that the revisions made by the Final Rule and IFR2 will not have an adverse effect in a material way on the nation's economy.

This is a significant regulatory action under section (3)(f)(1) of Executive Order 12866 and, therefore, the Final Rule and IFR2 have been reviewed by the Office of Management and Budget in accordance with that Order.

E. Unfunded Mandates Reform Act of 1995

Section 202 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 *et seq.*) requires that a covered agency prepare a budgetary impact statement before promulgating a rule that includes any Federal mandate that may result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year.

If a covered agency must prepare a budgetary impact statement, section 205 further requires that it select the most cost-effective and least burdensome alternative that achieves the objectives of the rule and is consistent with the statutory requirements. In addition, section 203 requires a plan for informing and advising any small government that may be significantly or uniquely impacted by the rule.

We have determined that the revisions made by the Final Rule and IFR2 will not require the expenditure by State, local, or Tribal governments, in the aggregate, or by the private sector, of more than $100 million in any one year. Accordingly, we have not prepared a budgetary impact statement, specifically addressed the regulatory alternatives considered, or prepared a plan for informing and advising any significantly or uniquely impacted small government.

F. Effective Date and Absence of Notice and Comment

In 1997, we provided a period of 60 days for public comment on IFR1. We fully reviewed all comments, and considered input from our State, local and Federal partners through our consultation process. The Final Rule will become effective on February 12, 2001.

For IFR2, we have determined, pursuant to 5 U.S.C. 553(b)(3)(B), that the statutory mandate to issue interim final regulations constitutes good cause for waiving notice and comment proceedings for IFR2. Moreover, because certain changes made by the 1999 Amendments are already in effect, it is important to have regulations implementing these provisions as soon as possible. Accordingly, we find that the issuance of a proposed rule rather than an interim final rule would be contrary to the public interest. IFR will become effective on February 12, 2001. IFR2 provides a 60-day comment

period, so that the public may submit comments on regulatory provisions implementing the 1999 Amendments. The information collection requirements associated with the rule will not be effective until approved by OMB.

G. Catalog of Federal Domestic Assistance Number

The program is listed in the *Catalog of Federal Domestic Assistance* at No. 17.253, ''Employment and Training Assistance-Welfare-to-Work Grants to States & Local Entities for Hard-to-Employ Welfare Recipient Programs.''

List of Subjects in 20 CFR Part 645

Employment programs, Grant programs-labor, Welfare-to-Work programs.

Signed at Washington, D.C. this 4th day of January, 2001.

Alexis M. Herman,

Secretary of Labor.

Raymond L. Bramucci,

Assistant Secretary of Labor, Employment and Training Administration.

For the reasons set out in the preamble, 20 CFR part 645 is revised to read as follows:

PART 645—PROVISIONS GOVERNING WELFARE-TO-WORK GRANTS

Subpart A—Scope and Purpose

Sec.
645.100 What does this part cover?
645.110 What are the purposes of the Welfare-to-Work program?
645.120 What definitions apply to this part?
645.125 What are the roles of the local and State governmental partners in the governance of the WtW program?
645.130 What are the effective dates for the Welfare-to-Work 1999 Amendments?
645.135 What is the effective date for spending Federal Welfare-to-Work formula funds on newly eligible participants and newly authorized services?

Subpart B—General Program and Administrative Requirements

645.200 What does this subpart cover?
645.210 What is meant by the terms ''entity'' and ''project'' in the statutory phrase ''an entity that operates a project'' with Welfare-to-Work funds?
645.211 How must Welfare-to-Work funds be spent by the operating entity?
645.212 Who may be served under the general eligibility and noncustodial parent eligibility (primary eligibility) provision?
645.213 Who may be served as an individual in the ''other eligibles'' (30 percent) provision?
645.214 How will Welfare-to-Work participant eligibility be determined?
645.215 What must a WtW operating entity that serves noncustodial parent participants do?
645.220 What activities are allowable under this part?
645.221 For what activities and services must local boards use contracts and vouchers?
645.225 How do Welfare-to-Work activities relate to activities provided under TANF and other related programs?
645.230 What general fiscal and administrative rules apply to the use of Federal funds?
645.233 What are the time limitations on the expenditure of Welfare-to-Work grant funds?
645.235 What types of activities are subject to the administrative cost limit on Welfare-to-Work grants?
645.240 What are the reporting requirements for Welfare-to-Work programs?
645.245 Who is responsible for oversight and monitoring of Welfare-to-Work grants?
645.250 What procedures apply to the resolution of findings arising from audits, investigations, monitoring, and oversight reviews?
645.255 What nondiscrimination protections apply to participants in Welfare-to-Work programs?
645.260 What health and safety provisions apply to participants in Welfare-to-Work programs?
645.265 What safeguards are there to ensure that participants in Welfare-to-Work employment activities do not displace other employees?
645.270 What procedures are there to ensure that currently employed workers may file grievances regarding displacement and that Welfare-to-Work participants in employment activities may file grievances regarding displacement, health and safety standards and gender discrimination?

Subpart C—Additional Formula Grant Administrative Requirements and Procedures

645.300 What constitutes an allowable match?
645.310 What assurances must a State provide that it will make the required matching expenditures?
645.315 What actions are to be taken if a State fails to make the required matching expenditures?
645.320 When will formula funds be reallotted, and what reallotment procedures will the Secretary use?

Subpart D—State Formula Grant Administration

645.400 Under what conditions may the Governor request a waiver to designate an alternate local administering agency?
645.410 What elements will the State use in distributing funds within the State?
645.415 What planning information must a State submit in order to receive a formula grant?
645.420 What factors will be used in measuring State performance?
645.425 What are the roles and responsibilities of the State(s) and local boards or alternate administering agencies?
645.430 How does the Welfare-to-Work program relate to the One-Stop system and Workforce Investment Act (WIA) programs?

Subpart E—Welfare-to-Work Competitive Grants

645.500 Who are eligible applicants for competitive grant funds?
645.510 What is the required consultation with the Governor?
645.515 What are the program and administrative requirements that apply to both the formula grants and competitive grants?
645.520 What are the application procedures and timeframes for competitive grant funds?
645.525 What special consideration will be given to rural areas and cities with large concentrations of poverty?

Subpart F—Administrative Appeal Process

645.800 What administrative remedies are available under this Part?

Authority: 42 U.S.C. 603 (a)(5)(C)(viii).

Subpart A—Scope and Purpose

§ 645.100 What does this part cover?

(a) Subpart A establishes regulatory provisions that apply to the Welfare-to-Work (WtW) programs conducted at the State and at the local area levels.

(b) Subpart B provides general program requirements applicable to all WtW formula and competitive funds. The provisions of this subpart govern how WtW funds must be spent, who is eligible to participate in the program, allowable activities and their relationship to TANF, Governor's projects for long-term recipients, administrative and fiscal provisions, and program oversight requirements. This subpart also addresses worker protections and the establishment of a State grievance system.

(c) Subpart C sets forth additional administrative standards and procedures for WtW Formula Grants, such as matching requirements and reallotment procedures.

(d) Subpart D sets forth the conditions under which the Governor may request a waiver to designate an alternate administering agency, sets forth the formula elements that must be included in the within-State distribution formula, the submission of a State annual plan, the factors for measuring State performance, and the roles and responsibilities of the States and the local boards or alternate administering agencies.

(e) Subpart E outlines general conditions and requirements for the WtW Competitive Grants.

(f) Subpart F sets forth the administrative appeals process.

(g) Regulatory provisions applicable to the Indian and Native American

Welfare-to-Work Program (INA WtW) are found at 20 CFR part 646.

§ 645.110 What are the purposes of the Welfare-to-Work Program?

The purposes of the WtW program are:

(a) To facilitate the placement of hard-to-employ welfare recipients and certain noncustodial parents into transitional employment opportunities which will lead to lasting unsubsidized employment and self-sufficiency;

(b) To provide a variety of activities, grounded in TANF's ''work first'' philosophy, to prepare individuals for, and to place them in, lasting unsubsidized employment;

(c) To provide for a variety of post-employment and job retention services which will assist the hard-to-employ welfare recipient and certain noncustodial parents to secure lasting unsubsidized employment;

(d) To provide targeted WtW funds to high poverty areas with large numbers of hard-to-employ welfare recipients.

§ 645.120 What definitions apply to this part?

The following definitions apply under this part:

Act means Title IV, Part A of the Social Security Act, 42 U.S.C. 601–619.

Adult means an individual who is not a minor child.

Chief Elected Official(s) (CEOs) means:

(1) The chief elected official of the sole unit of general local government in the service delivery area,

(2) The individual or individuals selected by the chief elected officials of all units of general local government in such area as their authorized representative, or

(3) In the case of a service delivery area designated under section 101(a)(4)(A)(iii) of JTPA, the representative of the chief elected official for such area (as defined in section 4(4)(C) of JTPA) or as defined in section 101 of the Workforce Investment Act of 1988.

Competitive grants means those grants in which WtW funds have been awarded by the Department under a competitive application process to local governments, PICs, and private entities (such as community development corporations, community-based and faith-based organizations, disability community organizations, and community action agencies) who apply in conjunction with a PIC or local government.

Department or *DOL* means the U.S. Department of Labor.

Employment activities means the activities enumerated at § 645.220(b).

ETA means the Employment and Training Administration of the U.S. Department of Labor.

Fiscal year (FY) means any 12-month period ending on September 30 of a calendar year.

Formula grants means those grants in which WtW funds have been allotted to each Welfare-to-Work State, based on a formula prescribed by the Act, which equally considers States' shares of the national number of poor individuals and of adult recipients of assistance under TANF. The State is required to distribute not less than 85 percent of the allotted formula grant funds to service delivery areas in the State; and the State may retain not more than 15 percent for projects to help long-term recipients of assistance enter unsubsidized employment. Unless otherwise specified, the term ''formula grant'' refers to the 85 percent and 15 percent funds.

Governor means the Chief Executive Officer of a State.

IV–D Agency (Child Support Enforcement) means the organizational unit in the State that has the responsibility for administering or supervising the administration of the State plan under title IV–D of the Act (SSA).

Job Training Partnership Act or *JTPA* means Public Law (Pub. L.) 97–300, as amended, 29 U.S.C. 1501, *et seq.*

Local area means a local workforce investment area designated under section 116 of the Workforce investment Act of 1998, or a service delivery area designated under section 101 of the Job Training partnership Act, as appropriate.

Local workforce investment board (local board) means a local board established under section 117 of the Workforce Investment Act, or a *Private Industry Council* established under section 102 of the Job Training Partnership Act (JTPA), which performs the functions authorized at section 103 of the JTPA, or an alternate administering agency designated under section 405(a)(5)(A)(vii)(II) of the Act and § 645.400 of this part.

Minor child means an individual who has not attained 18 years of age, or has not attained 19 years of age and is a full-time student in a secondary school (or in the equivalent level of vocational or technical training).

MOE means maintenance of effort. Under TANF, States are required to maintain a certain level of spending on welfare based on ''historic'' FY 1994 expenditure levels (Section 409(a)(7) of the Act).

PIC means a Private Industry Council established under Section 102 of the Job Training Partnership Act, which performs the functions authorized at Section 103 of the JTPA.

Political subdivision of a State means a unit of general purpose local government, as provided for in State laws and/or Constitution, which has the power to levy taxes and spend funds and which also has general corporate and police powers.

Private entity means any organization, public or private, which is not a local board, PIC or alternate administering agency or a political subdivision of a State.

PRWORA means the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law (Pub. L.) 104–193, which established the TANF program.

SDA means a service delivery area designated under section 101 of the Job Training Partnership Act or a local area designated under section 116 of the Workforce Investment Act of 1998, as appropriate.

Secretary means the Secretary of Labor.

Separate State program means a program operated outside of TANF in which the expenditures of State funds may count for TANF MOE purposes.

State means the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the US Virgin Islands, Guam, and American Samoa, unless otherwise specified.

State TANF Program means those funds expended under the State Family Assistance Grant (SFAG), the basic block grant allocated to the States under Section 403(a)(1) of the Act.

TANF means Temporary Assistance for Needy Families Program established under PRWORA.

TANF MOE means the expenditure of State funds that must be made in order to meet the Temporary Assistance for Needy Families Maintenance of Effort requirement.

Unemployed means the individual is without a job and wants and is available for work.

WIA means the Workforce Investment Act of 1998 (Pub. L. 105–220)(29 U.S.C. 2801 *et seq.*).

WtW means Welfare-to-Work.

WtW State means those States that the Secretary of Labor determines have met the five conditions established at Section 403(a)(5)(A)(ii) of the Act. Only States that are determined to be WtW States can receive WtW grant funds.

WtW statute means those provisions of the Balanced Budget Act of 1997 containing certain amendments to PRWORA and establishing the new Welfare-to-Work program, amending

Title IV of the Social Security Act, (codified at 42 U.S.C. 601–619).

§ 645.125 What are the roles of the local and State governmental partners in the governance of the WtW program?

(a) Local boards or alternate administering agencies, in coordination with CEO's should establish policies, interpretations, guidelines and definitions to implement provisions of the WtW statute to the extent that such policies, interpretations, guidelines and definitions are not inconsistent with the WtW statute or regulations or with State policies.

(b) States should establish policies, interpretations, guidelines and definitions to implement provisions of the WtW statute to the extent that such policies, interpretations, guidelines and definitions are not inconsistent with the WtW statute or regulations.

(c) The Secretary, in consultation with other Federal Agencies, as appropriate, may publish guidance on interpretations of statutory and regulatory provisions. State and local policies, interpretations, guidelines and definitions that are consistent with interpretations contained in such guidance will be considered to be consistent with the WtW statute for purposes of this section.

§ 645.130 What are the effective dates for the Welfare-to-Work 1999 Amendments?

The legislative changes made by the 1999 amendments:

(a) Are effective on November 29, 1999, except as provided in paragraphs (b) and (c) of this section;

(b) Provisions relating to the eligibility of participants for WtW competitive grants are effective on January 1, 2000;

(c)(1) Provisions relating to the eligibility of participants for WtW formula grants are effective on July 1, 2000, except that expenditures from allotments to the States, as discussed in § 645.135 of this subpart, must not have been made before October 1, 2000, for individuals who would not have been eligible under the criteria in effect before the changes made by the 1999 Amendments;

(2) Provisions authorizing pre-placement vocational educational training and job training for WtW formula grants, at § 645.220(b) of this part, are effective on July 1, 2000, except that expenditures from allotments to the States, as discussed in § 645.135 of this subpart, must not have been made before October 1, 2000.

§ 645.135 What is the effective date for spending Federal Welfare-to-Work formula funds on newly eligible participants and newly authorized services?

States and local areas may expend matching funds beginning July 1, 2000. States and local areas may incur unpaid obligations within the normal course of business, beginning July 1, 2000, provided that the timing of those transactions ensures that drawdown of federal Welfare-to-Work formula funds to liquidate the obligations did not occur until October 1, 2000.

Subpart B—General Program and Administrative Requirements

§ 645.200 What does this subpart cover?

This subpart provides general program and administrative requirements for WtW formula funds, including Governors' funds for long-term recipients of assistance, and for competitive grant funding (section 403(a)(5)).

§ 645.210 What is meant by the terms ''entity'' and ''project'' in the statutory phrase ''an entity that operates a project'' with Welfare-to-Work funds?

The terms ''entity'' and ''project'', in the statutory phrase ''an entity that operates a project'', means:

(a) For WtW substate formula funds:

(1) ''Entity'' means the PIC, local board (or the alternate administering agency designated by the Governor and approved by the Secretary pursuant to § 645.400 of this part) which administers the WtW substate formula funds in a local area(s). This entity is referred to in §§ 645.211 through 645.225 of this part as the ''operating entity.''

(2) ''Project'' means all activities, administrative and programmatic, supported by the total amount of the WtW substate formula funds allotted to the entity described in section (a)(1) of this paragraph.

(b) For WtW Governors' funds for long-term recipients of assistance:

(1) ''Entity'' means the agency, group, or organization to which the Governor has distributed any of the funds for long-term recipients of assistance, as described in § 645.410 (b) and (c) of this part. This entity is referred to in §§ 645.211 through 645.225 of this part as the ''operating entity.''

(2) ''Project'' means all activities, administrative and programmatic, supported by the total amount of one discrete award of WtW Governors' funds for long-term recipients of assistance awarded to the entity described in section (b)(1) of this paragraph.

(c) For competitive WtW funds:

(1) ''Entity'' means an eligible applicant, as described in § 645.500 of this part, which is awarded a competitive WtW grant. This entity is referred to in §§ 645.211 through 645.225 of this part as the ''operating entity.''

(2) ''Project'' means all of the activities, administrative and programmatic, supported by the total amount of one discrete WtW competitive grant awarded to the entity described in section (c)(1) of this paragraph (section 403(a)(5)(C)).

§ 645.211 How must Welfare-to-Work funds be spent by the operating entity?

An operating entity, as described in § 645.210 of this subpart, may spend not more than 30 percent of the WtW funds allotted to or awarded to the operating entity to assist individuals who meet the ''other eligibles'' eligibility requirements under § 645.213 of this subpart. The remaining funds allotted to or awarded to the operating entity are to be spent to benefit individuals who meet the ''general eligibility'' and/or ''noncustodial parents'' eligibility requirements, under § 645.212 of this subpart. (section 403(a)(5)(C) of the Act).

§ 645.212 Who may be served under the general eligibility and noncustodial parent eligibility (primary eligibility) provision?

An individual may be served under this provision if:

(a)(1) (S)he is currently receiving TANF assistance under a State TANF program, and/or its predecessor program, for at least 30 months, although the months do not have to be consecutive; or

(2) (S)he will become ineligible for assistance within 12 months due to either Federal or State-imposed time limits on the receipt of TANF assistance. This criterion includes individuals (as well as children of noncustodial parents) exempted from the time limits due to hardship under section 408(a)(7)(C) of the Act or due to a waiver because of domestic violence under section 402(a)(7) of the Act, who would become ineligible for assistance within 12 months without the exemption or waiver;

(b) (S)he is no longer receiving TANF assistance because (s)he has reached either the Federal five-year limit or a State-imposed time limit on receipt of TANF assistance (section 403(a)(5)(C) of the Act); or

(c) (S)he is a noncustodial parent of a minor child if:

(1) The noncustodial parent is:

(i) ''Unemployed,'' as defined in § 645.120 of this part,

(ii) ''Underemployed,'' as defined by the State in consultation with local

boards and WtW competitive grantees, or

(iii) ''Having difficulty paying child support obligations,'' as defined by the State in consultation with local boards and WtW competitive grantees and the State Child Support Enforcement (IV-D) Agency, and

(2) At least one of the following applies:

(i) The minor child, or the custodial parent of the minor child, meets the long-term recipient of TANF requirements of paragraph (a) of this section;

(ii) The minor child is receiving or is eligible for TANF benefits and services;

(iii) The minor child received TANF benefits and services during the preceding year; or

(iv) The minor child is receiving or eligible for assistance under the Food Stamp program, the Supplemental Security Income program, Medicaid, or the Children's Health Insurance Program; and

(3) The noncustodial parent is in compliance with the terms of a written or oral personal responsibility contract meeting the requirements of § 645.215 of this subpart.

(d) For purposes of determining whether an individual is receiving TANF assistance in paragraphs (a)(1) of this section and § 645.213(a), TANF assistance means any TANF benefits and services for the financially needy according to the appropriate income and resource criteria (if applicable) specified in the State TANF plan.

§ 645.213 Who may be served as an individual in the ''other eligibles'' (30 percent) provision?

Any individual may be served under this provision if (s)he:

(a) Is currently receiving TANF assistance (as described in § 645.212(d)) and either:

(1) Has characteristics associated with, or predictive of, long-term welfare dependence, such as having dropped out of school, teenage pregnancy, or having a poor work history. States, in consultation with the operating entity, may designate additional characteristics associated with, or predictive, of long term-welfare dependence; or

(2) Has significant barriers to self-sufficiency, under criteria established by the local board or alternate administering agency.

(b) Was in foster care under the responsibility of the State before s(he) attained 18 years of age and is at least 18 but not 25 years of age or older at the time of application for WtW. Eligible individuals include those who were recipients of foster care maintenance payments as defined in section 475(4) under part E of the Social Security Act, or

(c)(1) Is a custodial parent with income below 100 percent of the poverty line, determined in accordance with the most recent HHS Poverty Guidelines established under section 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97–35), including any revisions required by such section, applicable to a family of the size involved.

(2) For purposes of paragraph (c)(1) of this section, income is defined as total family income for the last six months, exclusive of unemployment compensation, child support payments, and old-age and survivors benefits received under section 202 of the Social Security Act (42 U.S.C. 402).

(3) A custodial parent with a disability whose own income meets the requirements of a program described in paragraph (c)(1) or (c)(3)(i) but who is a member of a family whose income does not meet such requirements is considered to have met the requirements of paragraph (c)(1) of this section.

§ 645.214 How will Welfare-to-Work participant eligibility be determined?

(a) The operating entity, as described in § 645.210(a)(1), (b)(1), and (c)(1) of this subpart, is accountable for ensuring that WtW funds are spent only on individuals eligible for WtW projects.

(b) The operating entity must ensure that there are mechanisms in place to determine WtW eligibility for individuals who are receiving TANF assistance. These mechanisms:

(1) Must include arrangements with the TANF agency to ensure that a WtW eligibility determination is based on information, current at the time of the WtW eligibility determination, about whether an individual is receiving TANF assistance, the length of receipt of TANF assistance, and when an individual may become ineligible for assistance, pursuant to §§ 645.212 and 645.213 of this part (section 403(a)(5)(I)(A)(ii)(dd)).

(2) May include a determination of WtW eligibility for characteristics of long-term welfare dependence and for significant barriers to self-sufficiency under § 645.213(a) of this subpart, based on information collected by the operating entity and/or the TANF agency up to six months prior to the WtW eligibility determination.

(c) The operating entity must ensure that there are mechanisms in place to determine WtW eligibility for individuals who have reached the time limit on receipt of TANF, under § 645.212(b) of this subpart; individuals who are not receiving TANF assistance (i.e., noncustodial parents under § 645.212(c) of this subpart; individuals who are former foster care recipients under § 645.213(b) of this subpart, and low-income custodial parents under § 645.213(c) of this subpart). The mechanisms for establishing noncustodial parent eligibility must include a process for applying the preference required under § 645.215(a) of this subpart, and may include an objective standard to be used as a presumptive determination for establishing the eligibility of the minor child for the programs specified in § 645.212(c)(2)(iv) of this subpart.

§ 645.215 What must a WtW operating entity that serves noncustodial parent participants do?

(a) In programs that serve noncustodial parents, the operating entity must give preference to those noncustodial parents who qualify under § 645.212(c)(2)(i) of this subpart over other noncustodial parents. The preference for admission into the program applies only to noncustodial parents and not to any other group eligible under the ''general eligibility'' provisions of § 645.212(a) or (b) or the ''other eligibles'' provisions of § 645.213. The preference does not require that the category of noncustodial parents eligible under § 645.212(c)(2)(i) must be exhausted before any other category of eligible noncustodial parents may be served. The operating entity may establish a process that gives preference to noncustodial parents eligible under § 645.212(c)(2)(i) and that also provides WtW services to noncustodial parents eligible under the other provisions of § 645.212(c)(2).

(b) In order to protect custodial parents and children who may be at risk of domestic violence, the operating entity must consult with domestic violence prevention and intervention organizations in the development of its WtW project serving noncustodial parents; and must not require the cooperation of the custodial parent as a condition of participation in the WtW program for either parent; and

(c) The operating entity must ensure that personal responsibility contracts:

(1) Take into account the employment and child support status of the noncustodial parent;

(2) Include all of the following parties:

(i) The noncustodial parent,

(ii) The operating entity, and

(iii) The agency responsible for administering the State Child Support Enforcement program as described under Title IV–D of the Act, unless the

operating entity demonstrates to the Secretary of Labor with written documentation that it is not able to coordinate with the State IV–D agency;

(3) Include the following elements:

(i) A commitment by the noncustodial parent to cooperate:

(A) In the establishment of paternity (if the participant is male) of the minor child at the earliest opportunity, through voluntary acknowledgment or other procedures, and

(B) In the establishment of a child support order;

(ii) A commitment by the noncustodial parent to cooperate in the payment of child support for the minor child. This commitment may include a modification of an existing support order to take into account:

(A) The ability of the noncustodial parent to pay such support; and

(B) The participation of the noncustodial parent in the WtW program, and

(iii) A commitment by the noncustodial parent to participate in employment or related activities that will enable the noncustodial parent to make regular child support payments. For noncustodial parents who have not reached 20 years of age, such activities may include:

(A) Completion of high school,

(B) Earning a general equivalency degree, or

(C) Participating in other education directly related to employment;

(iv) A description of the services to be provided to the noncustodial parent under the WtW program;

(4) Contain a commitment by the noncustodial parent to participate in the services that are described in the personal responsibility contract under paragraph (c)(3)(iv) of this section; and

(5) Be entered into no later than thirty (30) days after the individual is enrolled in and is receiving services through a WtW project funded under this part, unless the operating entity has determined that good cause exists to extend this period. This extension may not extend to a date more than ninety (90) days after the individual is enrolled in and receiving services through a WtW project funded under this part.

§ 645.220 What activities are allowable under this part?

Entities operating WtW projects may use WtW funds for the following:

(a) Job readiness activities, subject to the requirements of § 645.221 of this subpart.

(b) Vocational educational training or job training. A participant is limited to six calendar months of such training if (s)he is not also employed or participating in an employment activity, as described in paragraph (c) of this section.

(c) Employment activities which consist of any of the following:

(1) Community service programs;

(2) Work experience programs;

(3) Job creation through public or private sector employment wage subsidies; and

(4) On-the-job training.

(d) Job placement services subject to the requirements of § 645.221 of this subpart.

(e) Post-employment services which are provided after an individual is placed in one of the employment activities listed in paragraph (c) of this section, or in any other subsidized or unsubsidized job, subject to the requirements of § 645.221 of this subpart. Post-employment services include such services as:

(1) Basic educational skills training;

(2) Occupational skills training;

(3) English as a second language training; and

(4) Mentoring.

(f) Job retention services and support services that are provided after an individual is placed in a job readiness activity, as specified in paragraph (a) of this section; in vocational education or job training, as specified in paragraph (b) of this section; in one of the employment activities, as specified in paragraph (c) of this section, or in any other subsidized or unsubsidized job. WtW participants who are enrolled in Workforce Investment Act (WIA) or JTPA activities, such as occupational skills training, may also receive job retention and support services funded with WtW monies while they are participating in WIA activities. Job retention and support services can be provided with WtW funds only if they are not otherwise available to the participant. Job retention and support services include such services as:

(1) Transportation assistance;

(2) Substance abuse treatment (except that WtW funds may not be used to provide medical treatment);

(3) Child care assistance;

(4) Emergency or short term housing assistance; and

(5) Other supportive services.

(g) Individual development accounts which are established in accordance with the Act.

(h) Outreach, recruitment, intake, assessment, eligibility determination, development of an individualized service strategy, and case management may be incorporated in the design of any of the allowable activities listed in paragraphs (a) through (g) of this section (section 403(a)(5)(C) of the Act).

§ 645.221 For what activities and services must local boards use contracts or vouchers?

(a) Local boards and PIC's must provide the following activities and services through vouchers or contracts with public or private providers: the job readiness activities described in § 645.220(a) of this subpart, the job placement services described in § 645.220(d) of this subpart, and the post-employment services described in § 645.220(e) of this subpart. Job placement services provided with contracts or vouchers are subject to the payment requirements at § 645.230(a)(3) of this subpart. If an operating entity is not a local board or a PIC, it may provide such services directly.

(b) Local boards and PIC's which are directly providing job readiness activities or job placement and/or post-employment services must conform to the requirement in paragraph (a) of this section, to provide such services through contract or voucher, by February 12, 2001.

§ 645.225 How do Welfare-to-Work activities relate to activities provided through TANF and other related programs?

(a) Activities provided through WtW must be coordinated effectively at the State and local levels with activities being provided through TANF (section 403(a)(5)(A)(vii)(II)).

(b) The operating entity must ensure that there is an assessment of skills, prior work experience, employability, and other relevant information in place for each WtW participant. Where appropriate, the assessment performed by the TANF agency or JTPA should be used for this purpose.

(c) The operating entity must ensure that there is an individualized strategy for transition to unsubsidized employment in place for each participant which takes into account participant assessments, including the TANF assessment and any JTPA assessment. Where appropriate, the TANF individual responsibility plan (IRP), a WIA individual employment plan, or a JTPA individual service strategy should be used for this purpose.

(d) Coordination of resources should include not only those available through WtW and TANF grant funds, and the Child Care and Development Block Grant, but also those available through other related activities and programs such as the WIA or JTPA programs (One-Stop systems), the State employment service, private sector employers, labor organizations, business and trade associations, education agencies, housing agencies, community development corporations,

transportation agencies, community-based and faith-based organizations, disability community organizations, community action agencies, and colleges and universities which provide some of the assistance needed by the targeted population (section 402(a)(5)(A)).

§ 645.230 What general fiscal and administrative rules apply to the use of Federal funds?

(a) Uniform fiscal and administrative requirements.

(1) State, local, and Indian tribal government organizations are required to follow the common rule ''Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments'' which is codified in the DOL regulations at 29 CFR part 97.

(2) Institutions of higher education, hospitals, and other non-profit organizations and other commercial organizations are required to follow OMB Circular A–110 which is codified in the DOL regulations at 29 CFR part 95.

(3) In addition to the requirements at 29 CFR 95.48 and 29 CFR 97.36(i), contracts or vouchers for job placement services supported by funds provided for this program must include a provision to require that at least one-half (½) of the payment occur after an eligible individual placed into the workforce has been in the workforce for six (6) months. This provision applies only to placement in unsubsidized jobs (section 403(a)(5)(C)(i)).

(4) In addition to the requirements at 29 CFR 95.42 and 29 CFR 97.36(b)(3) which address codes of conduct and conflict of interest issues related to employees, it is also required that:

(i) A local board or alternate administering agency member shall neither cast a vote on, nor participate in, any decision making capacity on the provision of services by such member (or any organization which that member directly represents), nor on any matter which would provide any direct financial benefit to that member or a member of his immediate family; and

(ii) Neither membership on the local board or alternate administering agency nor the receipt of WtW funds to provide training and related services shall be construed, by itself, to violate these conflict of interest provisions.

(5) The addition method, described at 29 CFR 97.25(g)(2), is required for the use of all program income earned under WtW grants. When the cost of generating program income has been charged to the program, the gross amount earned must be added to the WtW program. However, the cost of generating program income must be subtracted from the amount earned to establish the net amount of program income available for use under the grants when these costs have not been charged to the WtW program.

(6) Any excess revenue over costs incurred for services provided by a governmental or non-profit entity must be included in program income earned.

(b) *Audit requirements.* All recipients and subrecipients of Department of Labor WtW awards must comply with the audit requirements codified at 29 CFR part 96.

(1) All governmental and non-profit organizations must follow the audit requirements of OMB Circular A–133 which is codified at 29 CFR part 99. This requirement is imposed at 29 CFR 97.26 for governmental organizations and at 29 CFR 95.26 for institutions of higher education, hospitals, and other non-profit organizations.

(2) The Department is responsible for audits of commercial organizations which are direct recipients of WtW grants.

(3) Commercial organizations which are WtW subrecipients and which expend more than the minimum level specified in OMB Circular A–133 ($300,000 as of April 15, 1999) must have either an organization-wide audit conducted in accordance with 29 CFR part 99 or a program specific financial and compliance audit.

(c) *Allowable costs/cost principles.* The DOL regulations at 29 CFR 95.27 and 29 CFR 97.22 identify the Federal principles for determining allowable costs which each kind of recipient and subrecipient must follow. For those selected items of cost requiring prior approval, the authority to grant or deny approval is delegated to the Governor.

(1) State, local, and Indian tribal government organizations must determine allowability of costs in accordance with the provisions of OMB Circular A–87, ''Cost Principles for State and Local Governments.''

(2) Non-profit organizations must determine allowability of costs in accordance with OMB Circular A–122, ''Cost Principles for Non-Profit Organizations.''

(3) Institutions of higher education must determine allowability of costs in accordance with OMB Circular A–21, ''Cost Principles for Education Institutions.''

(4) Hospitals must determine allowability of costs in accordance with the provisions of Appendix E of 45 CFR Part 74, ''Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals.''

(5) Commercial organizations and those non-profit organizations listed in Attachment C to OMB Circular A–122 must determine allowability of costs in accordance with the provisions of the Federal Acquisition Regulation (FAR) at 48 CFR Part 31.

(d) *Information technology costs.* In addition to the allowable cost provisions identified in § 645.235 of this subpart, the costs of information technology—computer hardware and software—will only be allowable under WtW grants when such computer technology is ''Year 2000 compliant.'' To meet this requirement, information technology must be able to accurately process date/time data (including, but not limited to, calculating, comparing and sequencing) from, into and between the twentieth and twenty-first centuries, and the years 1999 and 2000. The information technology must also be able to make leap year calculations. Furthermore, ''Year 2000 compliant'' information technology when used in combination with other technology shall accurately process date/time data if the other information technology properly exchanges date/time data with it.

(e) *Prohibition on Construction or Purchase of Facilities.* WtW federal funds may not be used to pay for the construction or purchase of facilities or buildings.

(f) *Prohibition on Business Start-up Costs.* WtW federal funds may not be used to cover the costs of business start-up and/or capital ventures.

(g) *Government-wide debarment and suspension, and government-wide drug-free workplace requirements.* All WtW grant recipients and subrecipients are required to comply with:

(1) Government-wide requirements for debarment and suspension which are codified at 29 CFR part 98, subparts A through E; and

(2) The government-wide requirements for a drug-free workplace. Recipients and subrecipients are required to comply with 29 CFR part 98, subpart F, except that the definition of ''grantee'' shall be read to include recipients and subrecipients.

(h) *Restrictions on Lobbying.* All WtW grant recipients and subrecipients are required to comply with the restrictions on lobbying which are codified in the DOL regulations at 29 CFR Part 93.

(i) *Nondiscrimination.* All WtW grant recipients and subrecipients are required to comply with the nondiscrimination provisions codified in the DOL regulations at 29 CFR parts 31 and 32. In addition, 29 CFR part 37 applies to recipients of WtW financial

assistance who are also WIA recipients and applies to recipients of WtW financial assistance who operate programs that are part of the One-Stop system established under the Workforce Investment Act, to the extent that the WtW programs and activities are being conducted as part of the One-Stop delivery system. Furthermore, WtW programs that are part of larger State agencies that are recipients of WIA title I financial assistance must also comply with the provisions of 29 CFR part 37. For purposes of this paragraph, the term ''recipient'' has the same meaning as the term is defined in 29 CFR part 37. That part also contains participant rights related to nondiscrimination.

(j) *Nepotism.* (1) No individual may be placed in a WtW employment activity if a member of that person's immediate family is engaged in an administrative capacity for the employing agency.

(2) To the extent that an applicable State or local legal requirement regarding nepotism is more restrictive than this provision, such State or local requirement shall be followed.

§ 645.233 What are the time limitations on the expenditure of Welfare-to-Work grant funds?

(a) Formula grant funds: The maximum time limit for the expenditure of a given fiscal year allotment is three years from the effective date of the Federal grant award to the State. The maximum time limit will be allowed and will be specified in the Department's formula grant document for each fiscal year of funds provided to the State. Any remaining funds that have not been expended at the end of the expenditure period must be returned to the Department in accordance with the applicable closeout procedures for formula grants.

(b) Competitive grant funds: The maximum time limit for the expenditure of these funds is three years from the effective date of award, but will, in all cases, be determined by the grant period and the terms and conditions specified in the Federal grant award agreement (including any applicable grant modification documents). Any remaining funds that have not been expended at the end of the approved grant period must be returned to the Department in accordance with the applicable closeout procedures for competitive grants (section 503(a)(5)(C)(vii)).

§ 645.235 What types of activities are subject to the administrative cost limit on Welfare-to-Work grants?

(a) *Administrative cost limitation (section 404(b)(1)).*—(1) *Formula grants to states.* Expenditures for administrative purposes under WtW formula grants to States are limited to fifteen percent (15%) of the grant award.

(2) *Competitive grants.* The limitation on expenditures for administrative purposes under WtW competitive grants will be specified in the grant agreement but in no case shall the limitation be more than fifteen percent (15%) of the grant award.

(3) Although administrative in nature, costs of information technology—computer hardware and software—needed for tracking and monitoring of WtW program, participant, or performance requirements, are excluded from the administrative cost limit calculation.

(b) The costs of administration are that allocable portion of necessary and allowable costs associated with those specific functions identified in paragraph (c) of this section for the administration of the WtW program and which are not related to the direct provision of services to participants. These costs can be both personnel and non-personnel and both direct and indirect.

(c) The costs of administration are the costs associated with performing the following functions:

(1) Performing overall general administrative functions and coordination of those functions under WtW including:

(i) Accounting, budgeting, financial and cash management functions;

(ii) Procurement and purchasing functions;

(iii) Property management functions;

(iv) Personnel management functions;

(v) Payroll functions;

(vi) Coordinating the resolution of findings arising from audits, reviews, investigations and incident reports;

(vii) Audit functions;

(viii) General legal services functions; and

(ix) Developing systems and procedures, including information systems, required for these administrative functions;

(2) Performing oversight and monitoring responsibilities related to WtW administrative functions,

(3) Costs of goods and services required for administrative functions of the program, including goods and services such as rental or purchase of equipment, utilities, office supplies, postage, and rental and maintenance of office space;

(4) Travel costs incurred for official business in carrying out administrative activities or the overall management of the WtW system; and

(5) Costs of information systems related to administrative functions (for example, personnel, procurement, purchasing, property management, accounting and payroll systems) including the purchase, systems development and operating costs of such systems.

(d)(1) Only that portion of the costs of WtW grantees that are associated with the performance of the administrative functions described in paragraph (c) of this section and awards to subrecipients or vendors that are solely for the performance of these administrative functions are classified as administrative costs. All other costs are considered to be for the direct provision of WtW activities and are classified as program costs.

(2) Personnel and related non-personnel costs of staff who perform both administrative functions specified in paragraph (c) of this section and programmatic services or activities are to be allocated as administrative or program costs to the benefitting cost objectives/categories based on documented distributions of actual time worked or other equitable cost allocation methods.

(3) Specific costs charged to an overhead or indirect cost pool that can be identified directly as a program cost may be charged as a program cost. Documentation of such charges must be maintained.

(4) Except as provided at paragraph (d)(1) of this section, all costs incurred for functions and activities of subrecipients and vendors are program costs.

(5) Costs of the following information systems including the purchase, systems development and operating (e.g., data entry) costs are charged to the program category.

(i) Tracking or monitoring of participant and performance information;

(ii) Employment statistics information, including job listing information, job skills information, and demand occupation information; and

(iii) Local area performance information.

§ 645.240 What are the reporting requirements for Welfare-to-Work programs?

(a) *General.* State formula and other direct competitive grant recipients must report financial and participant data in accordance with revised instructions that will be issued by the Department after consultation with the Secretary of Health and Human Services, States, and organizations that represent State or local governments. Reports must be submitted to the Department quarterly. Existing WtW financial reporting

instructions and formats are available on the WtW web site at *http://wtw.doleta.gov/linkpages/tegltein.htm.* The Internet reporting system for WtW grantees is accessible at *http://www.etareports.doleta.gov.*

(b) *Subrecipient reporting.* A State formula or other direct competitive grant recipient may impose different forms or formats, shorter due dates, and more frequent reporting requirements on subrecipients. However, the recipient is required to meet the reporting requirements imposed by the Department.

(c) *Financial reports.* Each grant recipient must submit financial reports to the Department. Reported expenditures and program income must be on the accrual basis of accounting and cumulative by fiscal year of appropriation. If the recipient's accounting records are not normally kept on the accrual basis of accounting, the recipient must develop accrual information through an analysis of the documentation on hand.

(d) *Participant reports.* Each grant recipient must submit participant reports to the Department. Participant data must be aggregate data, and, for most data elements, must be cumulative by fiscal year of appropriation.

(e) *Due dates.* Financial and participant reports are due no later than 45 days after the end of each quarter. A final financial and participant report is required 90 days after the expiration of a funding period or the termination of grant support.

§ 645.245 Who is responsible for oversight and monitoring of Welfare-to-Work grants?

(a) The Secretary may monitor all recipients and subrecipients of all grants awarded and funds expended under WtW. Federal oversight will be conducted primarily at the State level for formula grants and at the recipient level for competitive grants.

(b) The Governor must monitor local boards (or other approved administrative entities) funded under the State's formula allocated grants on a periodic basis for compliance with applicable laws and regulations. The Governor must develop and make available for review a State monitoring plan.

§ 645.250 What procedures apply to the resolution of findings arising from audits, investigations, monitoring and oversight reviews?

(a) Resolution of subrecipient level findings.

(1) The WtW grantee is responsible for the resolution of findings that arise from its monitoring reviews, investigations and audits (including OMB Circular A–133 audits) of subrecipients.

(2) A State or competitive grantee, as appropriate, must use the audit resolution, debt collection and appeal procedures that it uses for other Federal grant programs.

(3) If a State or competitive grantee, as appropriate, does not have such procedures, it must prescribe standards and procedures for the WtW grant program.

(b) Resolution of State level findings.

(1) The Secretary is responsible for the resolution of findings that arise from Federal audits, monitoring reviews, investigations, incident reports, and recipient level OMB Circular A–133 audits.

(2) The Secretary will use the DOL audit resolution process, consistent with the Single Audit Act of 1996 and OMB Circular A–133.

(3) A final determination issued by a grant officer pursuant to this process may be appealed to the DOL Office of Administrative Law Judges under the procedures at § 645.800.

(c) Resolution of nondiscrimination findings. Findings arising from investigations or reviews conducted under nondiscrimination laws shall be resolved in accordance with those laws and the applicable implementing regulations.

§ 645.255 What nondiscrimination protections apply to participants in Welfare-to-Work programs?

(a) All participants in WtW programs under this part shall have such rights as are available under all applicable Federal, State and local laws prohibiting discrimination, and their implementing regulations, including:

(1) The Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);

(3) The Americans with Disabilities Act of 1990 (42 U.S.C. 12101 *et seq.*); and

(4) Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*).

(b) Participants in work activities, as defined in section 407(a) of the Social Security Act, operated with WtW funds, shall not be discriminated against because of gender. Participants alleging gender discrimination may file a complaint using the State's grievance system procedures as described in § 645.270 of this subpart (section 403(a)(5)(J)(iii)) of the Act). Participants alleging gender discrimination in WtW programs conducted by One-Stop partners as part of the One-Stop delivery system may file a complaint using the complaint processing procedures developed and published by the State in accordance with the requirements of 29 CFR 37.70–37.80.

(c) Complaints alleging discrimination in violation of any applicable Federal, State or local law, such as Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*), the Pregnancy Discrimination Act (42 U.S.C. 2000e (paragraph k)), or Section 188 of the Workforce Investment Act of 1998 (29 U.S.C. 2938), as well as those listed in paragraph (a) of this section, shall be processed in accordance with those laws and the implementing regulations.

(d) Questions about or complaints alleging a violation of the nondiscrimination laws in paragraph (a) of this section may be directed or mailed to the Director, Civil Rights Center, U.S. Department of Labor, Room N–4123, 200 Constitution Avenue, NW, Washington, D.C. 20210 for processing.

§ 645.260 What health and safety provisions apply to participants in Welfare-to-Work programs?

(a) Participants in an employment activity operated with WtW funds, as defined in § 645.220 of this part, are subject to the same health and safety standards established under State and Federal law which are applicable to similarly employed employees, of the same employer, who are not participants in programs under WtW.

(b) Participants alleging a violation of these health and safety standards may file a complaint pursuant to the procedures contained in § 645.270 of this part (section 403(a)(5)(J)(ii)).

§ 645.265 What safeguards are there to ensure that participants in Welfare-to-Work employment activities do not displace other employees?

(a) An adult participating in an employment activity operated with WtW funds, as described in § 645.220 (b) and (c) of this subpart, may fill an established position vacancy subject to the limitations in paragraph (c) of this section.

(b) An employment activity operated with WtW funds, as described in § 645.220(c) of this subpart, must not violate existing contracts for services or collective bargaining agreements. Where such an employment activity would violate a collective bargaining agreement, the appropriate labor organization and employer must provide written concurrence before the employment activity is undertaken.

(c) An adult participating in an employment activity operated with WtW funds, as described in § 645.220(c)

of this subpart, must not be employed or assigned:

(1) When any other individual is on layoff from the same or any substantially equivalent job within the same organizational unit;

(2) If the employer has terminated the employment of any regular, unsubsidized employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the WtW participant; and,

(3) If the employer has caused an involuntary reduction to less than full time in hours of any employee in the same or substantially equivalent job within the same organizational unit.

(d) Regular employees and program participants alleging displacement may file a complaint pursuant to § 645.270 of this part (section 403(a)(5)(J)(i)).

§ 645.270 What procedures are there to ensure that currently employed workers may file grievances regarding displacement and that Welfare-to-Work participants in employment activities may file grievances regarding displacement, health and safety standards and gender discrimination?

(a) The State shall establish and maintain a grievance procedure for resolving complaints from:

(1) Regular employees that the placement of a participant in an employment activity operated with WtW funds, as described in § 645.220 of this part, violates any of the prohibitions described in § 645.265 of this part; and

(2) Program participants in an employment activity operated with WtW funds, as described in § 645.220 of this part, that any employment activity violates any of the prohibitions described in §§ 645.255(d), 645.260, or 645.265 of this part.

(b) Such grievance procedure should include an opportunity for informal resolution.

(c) If no informal resolution can be reached within the specified time as established by the State as part of its grievance procedure, such procedure shall provide an opportunity for the dissatisfied party to receive a hearing upon request.

(d) The State shall specify the time period and format for the hearing portion of the grievance procedure, as well as the time period by which the complainant will be provided the written decision by the State.

(e) A decision by the State under paragraph (d) of this section may be appealed by any dissatisfied party within 30 days of the receipt of the State's written decision, according to the time period and format for the appeals portion of the grievance procedure as specified by the State.

(f) The State shall designate the State agency which will be responsible for hearing appeals. This agency shall be independent of the State or local agency which is administering, or supervising the administration of the State TANF and WtW programs.

(g) No later than 120 days of receipt of an individual's original grievance, the State agency, as designated in paragraph (f) of this section, shall provide a written final determination of the individual's appeal.

(h) The grievance procedure shall include remedies for violations of §§ 645.255(d), 645.260, and 645.265 of this part which may continue during the grievance process and which may include:

(1) Suspension or termination of payments from funds provided under this part;

(2) Prohibition of placement of a WtW participant with an employer that has violated §§ 645.255(b), 645.260, and 645.265 of this part;

(3) Where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions, and privileges of employment; and,

(4) Where appropriate, other equitable relief (section 403(a)(5)(J)(iv)).

(i) Participants alleging gender discrimination by WtW programs that are not part of the One-Stop system may file a complaint using the grievance system procedures described above. Participants alleging gender discrimination by WtW programs that are part of the One-Stop system may file a complaint using the procedures developed by the State under the WIA nondiscrimination regulations at 29 CFR 37.70–37.80.

Subpart C—Additional Formula Grant Administrative Standards and Procedures

§ 645.300 What constitutes an allowable match?

(a) A State is entitled to receive two (2) dollars of Federal funds for every one (1) dollar of State match expenditures, up to the amount available for allotment to the State based on the State's percentage for WtW formula grant for the fiscal year. The State is not required to provide a level of match necessary to support the total amount available to it based on the State's percentage for WtW formula grant. However, if the proposed match is less than the amount required to support the full level of Federal funds, the grant amount will be reduced accordingly (section 403(a)(5)(A)(i)(I)).

(b) States shall follow the match or cost-sharing requirements of the ''Common Rule'' *Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments* (codified for DOL at 29 CFR 97.24). Paragraphs (b)(1)(i) and (ii), (b)(3), and (b)(4) and (c)(1) of this section are in addition to the common rule requirements. Also, paragraphs included in the common rule which relate to the use of donated buildings and other real property as match have been excluded from this provision.

(1) Only costs that would be allowable if paid for with WtW grant funds will be accepted as match.

(i) Because the use of Federal funds is prohibited for construction or purchase of facilities or buildings except where there is explicit statutory authority permitting it, costs incurred for the construction or purchase of facilities or buildings shall not be acceptable as match for a WtW grant.

(ii) Because the costs of construction or purchase of facilities or buildings are unallowable as match, the donation of a building or property as a third party in-kind contribution is also unallowable as a match for a WtW grant.

(2) A match or cost-sharing requirement may be satisfied by either or both of the following:

(i) Allowable costs incurred by the grantee, subgrantee or a cost type contractor under the assistance agreement. This includes allowable cost borne by non-Federal grants or by others and cash donations from non-Federal third parties.

(ii) The value of third party in-kind contributions applicable to the FY period to which the cost-sharing or matching requirement applies.

(3) No more than seventy-five percent (75%) of the total match expenditures may be in the form of third party in-kind contributions.

(4) Match expenditures must be recorded in the books of account of the entity that incurred the cost or received the contribution. These amounts may be rolled up and reported as aggregate State level match.

(c) Qualifications and exceptions—

(1) The matching requirements may not be met by the use of an employer's share of participant wage payments (*e.g.,* employer share of OJT wages).

(2) Costs borne by other Federal grant agreements. A cost-sharing or matching requirement may not be met by costs borne by another Federal grant. This prohibition does not apply to income earned by a grantee or subgrantee from a contract awarded under another Federal grant.

(3) General revenue sharing. For the purpose of this section, general revenue sharing funds distributed under 31 U.S.C. 6702 are not considered Federal grant funds.

(4) Cost or contributions counted towards other Federal cost-sharing requirements. Neither costs nor the values of third party in-kind contributions may count towards satisfying a cost-sharing or matching requirement of a grant agreement if they have been or will be counted towards satisfying a cost-sharing or matching requirement of another Federal grant agreement, a Federal procurement contract, or any other award of Federal funds.

(5) Costs financed by program income. Costs financed by program income, as defined in 29 CFR 97.25, shall not count towards satisfying a cost-sharing or matching requirement unless they are expressly permitted in the terms of the assistance agreement. (This use of general program income is described in 29 CFR 97.25(g)).

(6) Services or property financed by income earned by contractors. Contractors under a grant may earn income from the activities carried out under the contract in addition to the amounts earned from the party awarding the contract. No costs of services or property supported by this income may count toward satisfying a cost-sharing or matching requirement unless other provisions of the grant agreement expressly permit this kind of income to be used to meet the requirement.

(7) Records. Costs and third party in-kind contributions counting towards satisfying a cost-sharing or matching requirement must be verifiable from the records of grantees and subgrantee or cost-type contractors. These records must show how the value placed on third party in-kind contributions was derived. To the extent feasible, volunteer services will be supported by the same methods that the organization uses to support the allocability of regular personnel costs.

(8) Special standards for third party in-kind contributions.

(i) Third party in-kind contributions count towards satisfying a cost-sharing or matching requirement only where, if the party receiving the contributions were to pay for them, the payments would be allowable costs.

(ii) Some third party in-kind contributions are goods and services that, if the grantee, subgrantee, or contractor receiving the contribution had to pay for them, the payments would have been an indirect costs. Cost sharing or matching credit for such contributions shall be given only if the grantee, subgrantee, or contractor has established, along with its regular indirect cost rate, a special rate for allocating to individual projects or programs the value of the contributions.

(iii) A third party in-kind contribution to a fixed-price contract may count towards satisfying a cost-sharing or matching requirement only if it results in:

(A) An increase in the services or property provided under the contract (without additional cost to the grantee or subgrantee) or

(B) A cost savings to the grantee or subgrantee.

(iv) The values placed on third party in-kind contributions for cost-sharing or matching purposes must conform to the rules in the succeeding sections of this part. If a third party in-kind contribution is a type not treated in those sections, the value placed upon it must be fair and reasonable.

(d) Valuation of donated services.

(1) Volunteer services. Unpaid services provided to a grantee or subgrantee by individuals must be valued at rates consistent with those ordinarily paid for similar work in the grantee's or subgrantee's organization. If the grantee or subgrantee does not have employees performing similar work, the rates must be consistent with those ordinarily paid by other employers for similar work in the same labor market. In either case, a reasonable amount for fringe benefits may be included in the valuation.

(2) Employees of other organizations. When an employer other than a grantee, subgrantee, or cost-type contractor furnishes free of charge the services of an employee in the employee's normal line of work, the services must be valued at the employee's regular rate of pay exclusive of the employee's fringe benefits and overhead costs. If the services are in a different line of work, paragraph (d)(1) of this section applies.

(e) Valuation of third party donated supplies and loaned equipment or space.

(1) If a third party donates supplies, the contribution must be valued at the market value of the supplies at the time of donation.

(2) If a third party donates the use of equipment or space in a building but retains title, the contribution must be valued at:

(i) the fair rental rate of the equipment or space for property donated by non-governmental entities, or

(ii) a depreciation or use-allowance based on the property's market value at the time it was donated for property donated by governmental entities.

§ 645.310 What assurance must a State provide that it will make the required matching expenditures?

In its State plan, a State must provide a written estimate of planned matching expenditures and describe the process by which the funds will be tracked and reported to ensure that the State meets its projected match (section 403(a)(5)(A)(i)(I)).

§ 645.315 What actions are to be taken if a State fails to make the required matching expenditures?

(a) If State match expenditures do not satisfy the requirements of the FY grant award by the end of the three year fund availability period, the grant award amount will be reduced by the appropriate corresponding amount (*i.e.,* the grant will be reduced by two (2) dollars for each one (1) dollar shortfall in State matching funds) when the grant is closed out.

(b) Compliance with the fifteen percent (15%) administrative cost limit will be recalculated based on the FY formula grant award amount, as reduced under paragraph (a) of this section.

Subpart D—State Formula Grants Administration

§ 645.400 Under what conditions may the Governor request a waiver to designate an alternate local administering agency?

(a)(1) The Governor may include in the State's WtW Plan a waiver request to select an agency other than the local board or PIC to administer the program for one or more local areas or SDA's in a State; or

(2) When the Governor determines the local board or alternate administering agency has not coordinated its expenditures with the expenditure of funds provided to the State under TANF, pursuant to section 403(a)(5)(A)(vii)(II) of the Act, the Governor must request a waiver.

(b) The Governor shall bear the burden of proving that the designated alternate administering agency, rather than the local board or other alternate administering agency, would improve the effectiveness or efficiency of the administration of WtW funds in the SDA. The Governor's waiver request shall include information to meet that burden. The Governor shall provide a copy of the waiver request and any supporting information submitted to the Secretary to the local board and CEO of the local area for which an alternative administering agency is requested.

(c) The local board and CEO shall have fifteen (15) days in which to submit his or her written response to the Department. The local board and CEO

shall provide a copy of such response to the Governor.

(d) The Secretary will assess the waiver information submitted by the Governor, including input from the local board and CEO in reaching the decision whether to permit the use of an alternate administering agency.

(e) The Secretary shall approve a waiver request if she determines that the Governor has established that the designated alternate administering agency, rather than the local board or other administering agency, will improve the effectiveness or efficiency of the administration of WtW funds provided for the benefit of the local area.

(f) Where an alternate administering agency is approved by the Secretary, such administrative entity shall coordinate with the CEO for the applicable local area(s) regarding the expenditure of WtW grant funds in the local area(s).

(g) The decision of the Secretary to approve or deny a waiver request will be issued promptly and shall constitute final agency action.

§ 645.410 What elements will the State use in distributing funds within the State?

(a) Of the WtW funds allotted to the State, not less than 85 percent of the State allotment must be distributed to the local areas or SDA's in the State.

(1) The State shall prescribe a formula for determining the amount of funds to be distributed to each local area or SDA in the State using no factors other than the three factors described in paragraphs (2) and (3) of this paragraph;

(2) The formula prescribed by the Governor must include as one of the formula factors for distributing funds the provision at section 403(a)(5)(A)(vi)(I)(aa) of the Act. The Governor is to distribute funds to a local area or SDA based on the number by which the population of the area with an income that is less than the poverty line exceeds 7.5 percent of the total population of the area, compared to all such numbers in all such areas in the State. The Governor must assign a weight of not less than 50 percent to this factor;

(3) The Governor shall distribute the remaining funds, if any, to the local area or SDA's utilizing only one or both of the following factors:

(i) the local area or SDA's share of the number of adults receiving assistance under TANF or the predecessor program in the local area or SDA for 30 months or more (whether consecutive or not), relative to the number of such adults residing in the State;

(ii) the local area or SDA's share of the number of unemployed individuals residing in the local area or SDA, relative to the number of such individuals residing in the State.

(4) If the amount to be distributed to a local area or SDA by the Governor's formula is less than $100,000, the funds shall be available to be used by the Governor to fund projects described at paragraph (b) of this section.

(5) States shall use the guidance provided at section 403(a)(5)(D) of the Act in determining the number of individuals with an income that is less than the poverty line.

(6) Local Boards (or alternate administering agency) shall determine, pursuant to section 403(a)(5)(A)(vii)(I) of the Act, on which individual(s) and on which allowable activities to expend its WtW fund allocation.

(7) The State must distribute the local boards' or SDAs' allocations in a timely manner, but not longer than 30 days from receipt of the State's fund allotment.

(b) Of the funds allocated to the State, up to 15 percent of the funds may be retained at the State level to fund projects that appear likely to help long-term recipients of assistance enter unsubsidized employment. Any additional funds available as a result of the process described at paragraph (a)(4) of this section, shall also be available to be used to fund projects to help long-term recipients of assistance enter unsubsidized jobs.

(c) The Governors may distribute the funds retained pursuant to paragraph (b) of this section to a variety of workforce organizations, in addition to local boards or alternate administering agencies, and other entities such as One-Stop systems, private sector employers, labor organizations, business and trade associations, education agencies, housing agencies, community development corporations, transportation agencies, community-based and faith-based organizations, disability community organizations, community action agencies, and colleges and universities which provide some of the assistance needed by the targeted population.

§ 645.415 What planning information must a State submit in order to receive a formula grant?

(a) Each State seeking financial assistance under the formula grant portion of the WtW legislation must submit an annual plan meeting the requirements prescribed by the Secretary. This plan shall be in the form of an addendum to the TANF State plan and shall be submitted to the Secretaries of Labor and Health and Human Services.

(b) The Secretary shall review the State plan for compliance with the statutory and regulatory provisions of the WtW program. The Secretary's decision whether to accept a State plan as in compliance with the Act shall constitute final agency action.

(c) If the Governor has requested a waiver to permit the selection of an alternate administering agency in the State plan, the provisions of § 645.400 of this part shall apply (section 403(a)(5)(A)(ii)).

§ 645.420 What factors will be used in measuring State performance?

(a) The Department will use the following factors to measure State performance:

(1) Job entry rate as measured by the proportion of WtW participants who enter either subsidized employment or unsubsidized employment,

(2) Substantive job entry rate as measured by the proportion of WtW participants who are placed in or who have moved into subsidized or unsubsidized employment of 30 hours or more per week,

(3) Retention as measured by the proportion of WtW participants who remain in unsubsidized employment six months in the second subsequent quarter after the quarter in which placement occurred after initial placement, and

(4) Measured earnings gains of WtW participants who remain in unsubsidized employment six months after initial placement.

(b) The formula for calculating the performance bonus is weighted as follows:

(1) 30 percent on job entry rate,

(2) 30 percent on substantive job entry rate,

(3) 20 percent on retention in unsubsidized employment,

(4) 20 percent on earnings gains in unsubsidized employment.

The formula will reflect general economic conditions on a State-by-State basis.

(c) The formula shall serve as the basis for the award of FY 2000 bonus grants based on successful performance to be made in FY 2001 (section 403(a)(5)(E)).

§ 645.425 What are the roles and responsibilities of the State(s) and local boards or alternate administering agencies?

(a) State roles and responsibilities. A State:

(1) Designates State WtW administering agency;

(2) Provides overall administration of WtW funds, consistent with the WtW statute, WtW regulations and the State's WtW Plan;

(3) Develops the State WtW Plan in consultation and coordination with appropriate entities in substate areas, such as One-Stop systems, private sector employers, labor organizations, business and trade associations, education agencies, housing agencies, community development corporations, transportation agencies, community-based and faith-based organizations, disability community organizations, community action agencies, and colleges and universities which provide some of the assistance needed by the targeted population (section 403(a)(5)(A)(ii)(I)(cc));

(4) Distributes funds to SDAs, consistent with the provisions described at § 645.410(a) (section 403(a)(5)(A)(ii)(I)(bb));

(5) Conducts oversight and monitoring of WtW activities and fund expenditures at the State and local levels for compliance with applicable laws and regulations, consistent with the provisions at § 645.245 and provides technical assistance as appropriate;

(6) Ensures coordination of local board or alternate administering agency fund expenditures with the State TANF expenditures and other programs (section 403(a)(5)(A)(ii)(I)(dd));

(7) Determines whether to request waivers to select an alternate administering agency consistent with the provisions described at § 645.400 of this part (sections 403(a)(5)(A)(ii)(I)(ee) and 403(a)(5)(A)(vii)(III));

(8) Manages and distributes State level WtW funds (15 percent), consistent with the provisions at § 645.410(b) and (c) (section 403(a)(5)(A)(vi)(III));

(9) Ensures that the 15 percent administration limitation and the match requirement are met;

(10) Ensures that worker protections provisions are observed and establishes an appropriate grievance process, consistent with §§ 645.255 through 645.270 of this part (section 403(a)(5)(J));

(11) Provides comments on Competitive Grant Application(s) from eligible entities within the State, consistent with § 645.510 of this part (section 403(a)(5)(B)(ii));

(12) Cooperates with the Department of Health and Human Services on the evaluation of WtW programs (section 403(a)(5)(A)(ii)(III));

(13) Provides technical assistance to PIC's, local boards or alternate administering agencies; and

(14) Establishes internal reporting requirements to ensure Federal reports are accurate, complete and are submitted on a timely basis, consistent with § 645.240 of this part.

(b) Local Boards (or alternate administering agency) roles and responsibilities. A local board:

(1) Has sole authority, in coordination with CEOs, to expend formula funds (section 403(a)(5)(A)(vii)(I));

(2) Has authority to determine the individuals to be served in the local area (section 403(a)(5)(A)(vii)(I));

(3) Has authority to determine the services to be provided in the local area (section 403(a)(5)(A)(vii)(I));

(4) Ensures funds are expended on eligible recipients and on allowable activities, consistent with § 645.410(a)(5) of this part;

(5) Coordinates WtW fund expenditures with State TANF expenditures and other programs (section 403(a)(5)(A)(ii)(dd));

(6) Ensures that there is an assessment and an individual service strategy in place for each WtW participant, consistent with § 645.225(a) and (b) of this part;

(7) Conducts oversight and monitoring of subrecipients, consistent with the provisions at § 645.245 of this part;

(8) Ensures worker protection provisions and grievance process are observed, consistent with State guidelines (section 403(a)(5)(J)); and

(9) Consults with and provides comments on private entity Competitive Grant Application(s), consistent with the provisions at § 645.500(b)(1)(i) of this part.

§ 645.430 How does the Welfare-to-Work program relate to the One-Stop system and Workforce Investment Act (WIA) programs?

(a) As provided in the Workforce Investment Act regulations at 20 CFR 663.620, the local WtW formula grant program operator is a required partner in the One-Stop system. 20 CFR part 662 describes the roles of such partners in the One-Stop system and applies to the WtW formula grant program operators. A Memorandum of Understanding must be developed between the Local Workforce Investment Board and the WtW program that meets the requirements of 20 CFR 662.300, such as containing provisions relating to the services to be provided through the One-Stop system and methods for referring individuals between the One-Stop operator and the partner WtW program.

(b) WtW participants may also be served by the WIA programs and, through appropriate linkages and referrals, these individuals will have access to a broader range of activities and services through the cooperation of the WtW and WIA programs in the One-Stop system. For example, WtW participants, who are also determined eligible for WIA, and who need occupational skills training, may be referred through the One-Stop system to receive WIA training. These participants are also eligible to receive services available under WtW, such as transportation and child care while participating in the WIA activity.

(c) WIA participants, who are determined to be eligible for WtW, may also be served by the WtW programs through cooperation with the WIA programs in the One-Stop system. For example, WIA participants, who are also determined eligible for WtW, may be referred to the WtW program for job placement and other WtW assistance.

(d) 29 CFR part 37 applies to recipients of WtW financial assistance who operate programs that are part of the One-Stop system established under WIA to the extent that the WtW programs and activities are being conducted as part of the One-Stop delivery system.

Subpart E—Welfare-To-Work Competitive Grants

§ 645.500 Who are eligible applicants for competitive grants?

(a) Eligible applicants for competitive grants are:

(1) Local boards or alternate administering agencies

(2) Political subdivisions of a State; and

(3) Private entities, as defined in § 645.120 of this part, including nonprofit organizations such as community development corporations, community-based and faith-based organizations, disability community organizations, community action agencies, and public and private colleges and universities, and other qualified private organizations.

(b) Entities other than a local board or alternate administering agency or a political subdivision of the State must submit an application for competitive grant funds in conjunction with the applicable local board or alternate administering agency or political subdivision.

(1) The term ''in conjunction with'' shall mean that the application submitted by such an entity must include a signed certification by both the applicant and either the applicable local board or alternate administering agency or political subdivision that:

(i) The applicant has consulted with the applicable local board or alternate

administering agency or political subdivision during the development of the application; and

(ii) The activities proposed in the application are consistent with, and will be coordinated with, WtW efforts of the local board or alternate administering agency or political subdivision.

(2) If the applicant is unable to include such a certification in its application, the applicant will be required to certify, and provide information indicating that efforts were undertaken to consult with the local board or alternate administering agency or political subdivision and that the local board or alternate administering agency or political subdivision was provided a sufficient opportunity to cooperate in the development of the project plan and to review and comment on the application prior to its submission to the Secretary. ''Sufficient opportunity for local Board or alternate administering agency or political subdivision review and comment'' shall mean at least 30 calendar days.

(3) The certification described in paragraph (b)(1) of this section, or the evidence of efforts to consult described in paragraph (b)(2), must be with each local board or alternate administering agency or political subdivision included in the geographic area in which the project proposed in the application is to operate (section 403(a)(5)(B)(ii)).

§ 645.510 What is the required consultation with the Governor?

(a) All applicants for competitive grants, including local boards or alternate administering agencies and political subdivisions, must consult with the Governor by submitting their application to the Governor or the designated State administrative entity for the WtW program for review and comment prior to submission of the application to the Secretary. The application submitted to the Secretary must include:

(1) Comments on the application from the State; or

(2) Information indicating that the State was provided a sufficient opportunity for review and comment prior to submission to the Secretary. ''Sufficient opportunity for State review and comment'' shall mean at least 15 calendar days.

(b) For private entity applicants, the submission of the application for State review and comment must follow the 30 day period provided for local board or alternate administering agency/political subdivision review. Evidence of local board or alternate administering agency or political subdivision review should be included in the submission to the State (section 403(a)(5)(B)(ii)).

§ 645.515 What are the program and administrative requirements that apply to both the formula grants and competitive grants?

(a) All of the general program requirements and administrative standards set by 29 CFR Part 645 Subpart B apply (section 403(a)(5)(C) and section 404(b)).

(b) In addition, competitive grants will be subject to:

(1) Supplemental reporting requirements; and

(2) Additional monitoring and oversight requirements based on the negotiated scope-of-work of individual grant awards (section 403(a)(5)(B)(iii) and (v)).

§ 645.520 What are the application procedures and timeframes for competitive grant funds?

(a) The Secretary shall establish appropriate application procedures, selection criteria and an approval process to ensure that grant awards accomplish the purpose of the competitive grant funds and that available funds are used in an effective manner.

(b) The Secretary shall publish such procedures in the **Federal Register** and establish submission timeframes in a manner that allows eligible applicants sufficient time to develop and submit quality project plans (section 403(a)(5)(B)(i) and (iii)).

§ 645.525 What special consideration will be given to rural areas and cities with large concentrations of poverty?

(a) Competitive grant awards will be targeted to geographic areas of significant need. In developing application procedures, special consideration will be given to rural areas and cities with large concentrations of residents living in poverty.

(b) Grant application guidelines will clarify specific requirements for documenting need in the local area (section 403(a)(5)(B)(iv)).

Subpart F—Administrative Appeal Process

§ 645.800 What administrative remedies are available under this Part?

(a) Within 21 days of receipt of a final determination that has directly imposed a sanction or corrective action pursuant to § 645.250(b) of this part, a recipient, subrecipient, or a vendor directly against which the Grant Officer has imposed a sanction or corrective action, may request a hearing before the Department of Labor Office of Administrative Law Judges, pursuant to the provisions of 29 CFR part 96 subpart 96.6.

(b) In accordance with 29 CFR 96.603(b)(2), the rules of practice and procedure published at 29 CFR part 18 shall govern the conduct of hearings under this section, except that a request for hearing under this section shall not be considered a complaint to which the filing of an answer by DOL or a DOL agency is required. Technical rules of evidence shall not apply to a hearing conducted pursuant to this part; however, rules or principles designed to assure production of the most credible evidence available and to subject testimony to cross-examination shall apply.

(c) The decision of the Administrative Law Judge (ALJ) shall constitute final agency action unless, within 20 days of the decision, a party dissatisfied with the decision of the ALJ has filed a petition for review with the Administrative Review Board (ARB) (established pursuant to the provisions of Secretary's Order No. 2–96, published at 61 FR 19977 (May 3, 1996)), specifically identifying the procedure, fact, law or policy to which exception is taken. Any exception not specifically urged shall be deemed to have been waived. A copy of the petition for review must be sent to the opposing party at that time. Thereafter, the decision of the ALJ shall constitute final agency action unless the ARB, within 30 days of the filing of the petition for review, has notified the parties that the case has been accepted for review. Any case accepted by the ARB shall be decided within 120 days of such acceptance. If not so decided, the decision of the ALJ shall constitute final agency action.

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Federal Register

Thursday,

January 11, 2001

Part IV

Department of the Treasury

Office of Foreign Assets Control

31 CFR Parts 501, 538, 545

Reporting and Procedures Regulations; Sudanese Sanctions Regulations; Taliban (Afghanistan) Sanctions Regulations; Final Rules

DEPARTMENT OF THE TREASURY

Office of Foreign Assets Control

31 CFR Parts 501, 538, 545

Reporting and Procedures Regulations; Sudanese Sanctions Regulations; Taliban (Afghanistan) Sanctions Regulations

AGENCY: Office of Foreign Assets Control, Treasury.

ACTION: Interim rule; amendments.

SUMMARY: The Office of Foreign Assets Control of the U.S. Department of the Treasury is amending provisions relating to the registration of nongovernmental organizations in the Reporting and Procedures Regulations and Sudanese Sanctions Regulations and is issuing the Taliban (Afghanistan) Sanctions Regulations to implement the President's declaration of a national emergency and imposition of sanctions against the Taliban in Executive Order 13129 of July 4, 1999.

DATES: *Effective Date:* January 11, 2001.

Comments: Written comments must be received no later than February 12, 2001. Comments may be submitted either via regular mail to the attention of David W. Mills, Chief, Policy Planning and Program Management Division, rm. 2176 Main Treasury Annex, 1500 Pennsylvania Ave. NW., Washington, DC 20220 or via OFAC's website (*http://www.treas.gov/ofac*).

FOR FURTHER INFORMATION CONTACT: Dennis P. Wood, Chief of Compliance Programs, tel.: 202/622–2490, Steven I. Pinter, Acting Chief of Licensing, tel.: 202/622–2480, or Barbara C. Hammerle, Acting Chief Counsel, tel.: 202/622–2410, Office of Foreign Assets Control, Department of the Treasury, Washington, DC 20220.

SUPPLEMENTARY INFORMATION:

Electronic Availability

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Background

The Treasury Department is adding paragraph (c) to § 501.801 of the Reporting and Procedures Regulations, 31 CFR Part 501, to require registration of nongovernmental organizations seeking permission to perform humanitarian and religious activities otherwise prohibited in geographic areas subject to economic sanctions. This change will harmonize practices across all sanctions programs containing nongovernmental organization registration provisions. As a consequence of this change, OFAC is amending the nongovernmental registration provision contained in § 538.521 of the Sudanese Sanctions Regulations, 31 CFR Part 538, to reference the new paragraph in § 501.801.

On July 4, 1999, the President issued Executive Order 13129 (64 FR 36759, July 7, 1999), declaring a national emergency with respect to the actions and policies of the Taliban in Afghanistan and invoking the authority of, *inter alia,* the International Emergency Economic Powers Act, 50 U.S.C. 1701–1706 (''IEEPA''). The order blocks all property and interests in property of the Taliban that are in the United States, that are or hereafter come within the United States, or that are or hereafter come within the possession or control of U.S. persons, including overseas branches of U.S. entities. The order also prohibits trade with the Taliban or involving the territory of Afghanistan controlled by the Taliban. The order authorizes the Secretary of the Treasury, in consultation with the Secretary of State and the Attorney General, to take such actions, including the promulgation of rules and regulations, as may be necessary to carry out the purposes of the order. On October 15, 1999, the United Nations Security Council issued Resolution 1267 which, among other things, directs member states to freeze funds and other financial resources of the Taliban (effective November 14, 1999). To implement Executive Order 13129, and consistent with United Nations Security Council Resolution (''UNSCR'') 1267, the Office of Foreign Assets Control of the U.S. Department of the Treasury is promulgating the Taliban (Afghanistan) Sanctions Regulations, 31 CFR Part 545 (the ''Regulations'').

Paragraph (a) of § 545.201 of the Regulations implements section 1(a) of Executive Order 13129 (the ''Executive Order'') by blocking all property and interests in property of the Taliban that are in the United States, that hereafter come within the United States, or that are or hereafter come within the possession or control of U.S. persons, including their overseas branches. To implement section 1(b) of the Executive Order, § 545.201(a) also blocks all property and interests in property of persons determined by the Secretary of the Treasury, in consultation with the Secretary of State and the Attorney General, to be owned or controlled by, or to be acting for or on behalf of, or to provide financial, material, or technological support for, or services in support of, the Taliban and those associated with the Taliban. Persons coming within any of these categories are referred to as *persons whose property or interests in property are blocked pursuant to § 545.201* in these Regulations. Section 545.201(b) implements section 2(a) of the Executive Order by prohibiting U.S. persons from transferring, paying, exporting, withdrawing or otherwise dealing in property and interests in property blocked pursuant to the Executive Order.

Section 545.204 implements section 2(b) of the Executive Order by prohibiting the exportation, reexportation, sale, or supply, directly or indirectly, from the United States or by a U.S. person, wherever located, of any goods, software, technology (including technical data), or services to the territory of Afghanistan controlled by the Taliban or to the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201.

Section 545.205 implements section 2(c) of the Executive Order by prohibiting the importation into the United States of goods, software, technology, or services owned or controlled by the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 or from the territory of Afghanistan controlled by the Taliban.

Section 545.206 of the Regulations implements section 2(d) of the Executive Order by prohibiting actions that evade, avoid or attempt to violate the Regulations. This section also forbids conspiracies to violate the Regulations, implementing section 2(e) of the Executive Order.

Section 545.208 details those types of transactions that are exempt from the Regulations. Exempted are transactions related to personal communications, information and informational materials, travel, official U.S.

government business, journalistic activity, and donations of articles to relieve human suffering. These exemptions derive from the exemptions set out in section 203(b) of IEEPA (50 U.S.C. 1702(b)).

Defined terms are set forth in subpart C and interpretive provisions in subpart D of the Regulations. Section 545.408 of subpart D pertains to the prohibitions set forth in §§ 545.201 and 545.204 through 545.206, which extend to U.S. persons wherever they may be located. Consequently, § 545.408 makes clear that even while outside the United States, U.S. persons are prohibited from dealing in property in which the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 have an interest, including dealing in goods, software, technology or services owned or controlled by the Taliban or of persons whose property or interests in property are blocked pursuant to § 545.201. Similarly, U.S. persons may not participate in the exportation or importation of goods, software, technology, or services into or out of the territory of Afghanistan controlled by the Taliban.

Transactions otherwise prohibited under part 545 but found to be consistent with U.S. policy may be authorized by one of the general licenses contained in subpart E or by a specific license issued pursuant to the procedures described in subpart D of part 501 of 31 CFR chapter V. Penalties for violations of the Regulations are described in subpart G of the Regulations.

The general licenses contained in subpart E include an authorization for U.S. financial institutions to debit blocked accounts for normal service charges in § 545.504. Subject to the presentation of proof satisfactory to the U.S. Customs Service, under § 545.505 importation will be permitted of certain goods, software, or technology (but not services) from the territory of Afghanistan controlled by the Taliban that left that territory before the effective date of the Executive Order. This authority does not extend to those goods or that software or technology owned or controlled by the Taliban or by persons whose property or interests in property are blocked pursuant to § 545.201.

Section 545.506 permits the importation into the United States of gifts valued at no more than $100 per recipient. Section 545.507 allows travelers to enter or depart from the United States with their accompanied baggage. Sections 545.508 and 545.509 authorize transactions related to telecommunications and mail services. Section 545.510 permits the importation and exportation of household and personal effects.

Section 545.511 references the provision in § 501.801 of 31 CFR, chapter V, permitting the registration of nongovernmental organizations involved in humanitarian or religious activities intended to relieve human suffering. Registration numbers authorize nongovernmental organizations to engage in transactions otherwise prohibited by the Taliban (Afghanistan) Sanctions Regulations, including the exportation of goods, software, technology, and services to the territory of Afghanistan controlled by the Taliban, and the transfer of funds to and from the territory of Afghanistan controlled by the Taliban if the funds are intended for the purpose of relieving human suffering.

Section 545.512 grants a general license for payments to U.S. persons for obligations that arose prior to the effective date. Section 545.513 authorizes the provision and exportation of certain legal services, provided that receipt of payment for such services is specifically licensed. Section 545.514 provides for specific licensing of payments for services to aircraft provided by the Taliban in connection with overflights or emergency landings. That section also indicates that specific licenses may be issued for the exportation to the territory of Afghanistan controlled by the Taliban of goods, software, technology, and services to ensure safe operation of aircraft.

Section 545.515 permits U.S. persons to perfect and protect intellectual property rights in the territory of Afghanistan controlled by the Taliban. Section 545.516 permits U.S. financial institutions to process funds transfers to or from the territory of Afghanistan controlled by the Taliban where such transfers are related to transactions exempted from or authorized under the Regulations. Section 545.517 authorizes provision of certain emergency medical services, provided that payment for such services is specifically licensed. Section 545.518 allows investment and reinvestment of blocked assets as long as immediate benefits do not accrue to persons whose property or interests in property are blocked pursuant to § 545.201.

Section 545.519 indicates the availability of specific licenses to allow payments for goods or services exported prior to the effective date. Section 545.520 permits noncommercial remittances to or from the territory of Afghanistan controlled by the Taliban. Section 545.521 allows U.S. citizens permanently residing in the territory of Afghanistan controlled by the Taliban to engage in transactions related to their necessary maintenance and living expenses. Section 545.522 authorizes U.S. financial institutions to operate accounts for private persons in the territory of Afghanistan controlled by the Taliban (provided that person's property is not blocked pursuant to § 545.201).

Sections 545.523 and 545.524 permit the extension or renewal of letters of credit (by general license) or loans (by specific license). Where the State Department has issued visas, § 545.525 permits the importation of services and the completion of activities consistent with the visas. Section 545.526 allows the importation of goods, software, technology or services for diplomatic missions. Section 545.527 allows importation of diplomatic pouches and their contents.

In light of the recent passage of the Trade Sanctions Reform and Export Enhancement Act of 2000, Title IX of Public Law 106–387 (October 28, 2000)(the ''Act''), requiring the President to terminate unilateral sanctions on the exportation of agricultural commodities and medicine and medical devices, section 3 of the Executive Order, permitting the commercial sale of agricultural commodities and products, medicine, and medical equipment to private persons or nongovernmental entities in the territory of Afghanistan controlled by the Taliban, is not being addressed in these Regulations. Regulations implementing the Act will be issued separately.

Because the Regulations involve a foreign affairs function, the provisions of Executive Order 12866 and the Administrative Procedure Act (5 U.S.C. 553) (the ''APA'') requiring notice of proposed rulemaking, opportunity for public participation, and delay in effective date are inapplicable. However, because of the importance of the issues raised by these regulations, this rule is issued in interim form and comments will be considered in the development of final regulations. Accordingly, the Department encourages interested persons who wish to comment to do so at the earliest possible time to permit the fullest consideration of their views.

The period for submission of comments will close February 12, 2001. The Department will consider all comments received before the close of the comment period in developing final regulations. Comments received after the end of the comment period will be

considered if possible, but their consideration cannot be assured. The Department will not accept public comments accompanied by a request that a part or all of the submission be treated confidentially because of its business proprietary nature or for any other reason. The Department will return such comments and materials when submitted by regular mail to the person submitting the comments and will not consider them in the development of final regulations. In the interest of accuracy and completeness, the Department requires comments in written form.

All public comments on these regulations will be a matter of public record. Copies of the public record concerning these regulations will be made available, not sooner than March 12, 2001, and will be obtainable from OFAC's website (*http://www.treas.gov/ofac*). If that service is unavailable, written requests for copies may be sent to: Office of Foreign Assets Control, U.S. Department of the Treasury, 1500 Pennsylvania Ave., NW., Washington, DC 20220, Attn: Merete Evans.

Because no notice of proposed rulemaking is required for this rule, the Regulatory Flexibility Act (5 U.S.C. 601–612) does not apply.

Paperwork Reduction Act

The collections of information related to the Regulations are contained in 31 CFR part 501 (the ''Reporting and Procedures Regulations''). Pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3507), those collections of information have been previously approved by the Office of Management and Budget (''OMB'') under control number 1505–0164. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid control number.

List of Subjects

31 CFR Part 501

Administrative practice and procedure, Banks, banking, Blocking of assets, Foreign trade, Reporting and recordkeeping requirements.

31 CFR Part 538

Administrative practice and procedure, Agricultural commodities, Banks, banking, Blocking of assets, Drugs, Exports, Foreign trade, Humanitarian aid, Imports, Medical devices, Penalties, Reporting and recordkeeping requirements, Specially designated nationals, Sudan, Terrorism, Transportation.

31 CFR Part 545

Administrative practice and procedure, Afghanistan, Agricultural commodities, Banks, banking, Blocking of assets, Drugs, Exports, Foreign trade, Humanitarian aid, Imports, Medical devices, Penalties reporting and recordkeeping requirements, Specially designated nationals, Taliban, Transportation.

For the reasons set forth in the preamble, 31 CFR parts 501 and 538 are amended and part 545 is added to read as follows:

PART 501—REPORTING AND PROCEDURES REGULATIONS

1. The authority citation for part 501 continues to read as follows:

Authority: 22 U.S.C. 287c; 31 U.S.C. 321(b); 50 U.S.C. 1701–1706; 50 U.S.C. App. 1–44.

Subpart D—Procedures

2. Section 501.801 is amended by adding paragraph (c) to read as follows:

§ 501.801 Licensing.

* * * * *

(c) *Registration of nongovernmental organizations*—(1) *Purpose of registration.* For those parts of this chapter specifically authorizing the registration of nongovernmental organizations (''NGOs''), registration numbers may be issued on a case-by-case basis to NGOs involved in humanitarian or religious activities in countries or geographic areas subject to economic sanctions pursuant to this chapter V. A registration number authorizes certain transactions by or on behalf of the registered NGO otherwise prohibited by the specific part with respect to which the registration number is issued, including the exportation of goods, services, and funds to the country or geographic area subject to such part for the purpose of relieving human suffering. The transactions authorized for registered NGOs either will be specified by the statement of licensing policy in the part under which the registration number is issued or by the Office of Foreign Assets Control letter issuing the registration number.

(2) *Application information to be supplied.* Applications for registration numbers should be submitted to the Compliance Programs Division, Office of Foreign Assets Control, U.S. Department of the Treasury, 1500 Pennsylvania Avenue, NW., Annex, Washington, DC 20220, or by facsimile to (202) 622–2426, and must include:

(i) The organization's name in English, in the language of origin, and any acronym or other names used to identify the organization;

(ii) Address and phone number of the organization's headquarters location;

(iii) Full name in English, in the language of origin, and any acronym or other names used, as well as nationality, citizenship, current country of residence, place and date of birth for key staff at the organization's headquarters, such as the chairman and board members, president, director, etc.;

(iv) Identification of field offices or partner offices elsewhere, including addresses, phone numbers, and organizational names used, as well as the identification of the senior officer(s) at these locations, including the person's name, position, nationality, citizenship, and date of birth (names of individuals and organizations shall be provided in English, in the language of origin, and shall include any acronym or other names used to identify the individuals or organizations);

(v) Identification of subcontracting organizations, if any, to the extent known or contemplated at the time of the application;

(vi) Existing sources of income, such as official grants, private endowments, commercial activities;

(vii) Financial institutions that hold deposits on behalf of or extend lines of credit to the organization (names of individuals and organizations shall be provided in English, in the language of origin, and shall include any acronym or other names used to identify the individuals or organizations);

(viii) Independent accounting firms, if employed in the production of the organization's financial statements (names of individuals and organizations shall be provided in English, in the language of origin, and shall include any acronym or other names used to identify the individuals or organizations);

(ix) A detailed description of the organization's humanitarian or religious activities and projects in countries or geographic areas subject to economic sanctions pursuant to this chapter V;

(x) Most recent official registry documents, annual reports, and annual filings with the pertinent government, as applicable; and

(xi) Names and addresses of organizations to which the applicant currently provides or proposes to provide funding, services or material support, to the extent known at the time of the vetting, as applicable.

(3) *Use of registration number.* Registered NGOs conducting transactions authorized by their registrations to support their humanitarian or religious activities

pursuant to any part of this chapter should reference the registration number on all payments and funds transfers and on all related documentation, including all purchasing, shipping, and financing documents.

(4) *Limitations.* Registered NGOs are not authorized to make remittances from blocked accounts. Registration numbers are not transferable and may be revoked or modified at any time at the discretion of the Director, Office of Foreign Assets Control. Registration numbers do not excuse compliance with any law or regulation administered by the Office of Foreign Assets Control or any other agency (including reporting requirements) applicable to the transaction(s) herein authorized, nor does it release the Registrant or third parties from civil or criminal liability for violation of any law or regulation.

(5) *Prior numbers.* Registration numbers already issued remain in effect.

PART 538—SUDANESE SANCTIONS REGULATIONS

1. The authority citation for part 538 continues to read as follows:

Authority: 3 U.S.C. 301; 31 U.S.C. 321(b); 50 U.S.C. 1601–1651, 1701–1706; E.O. 13067, 62 FR 59989, 3 CFR, 1997 Comp., p. 230.

Subpart E—Licenses, Authorizations, and Statements of Licensing Policy

2. Section 538.521 is revised to read as follows:

§ 538.521 Registration of nongovernmental organizations for humanitarian or religious activities.

(a) Registration numbers may be issued on a case-by-case basis for the registration of nongovernmental organizations involved in humanitarian or religious activities in Sudan, authorizing transactions by such organizations otherwise prohibited by this part, including the exportation of services, goods, software, or technology to Sudan and the transfer of funds to and from Sudan for the purpose of relieving human suffering. Applicants for registration numbers must comply with the requirements of § 501.801(c), 31 CFR chapter V.

(b) This section does not authorize transfers from blocked accounts.

Note to § 538.521: Registration does not excuse a U.S. person from compliance with other applicable U.S. laws governing the exportation or reexportation of U.S.-origin goods, software, or technology (including technical data). See, e.g., the Export Administration Regulations administered by the U.S. Department of Commerce (15 CFR parts 730–774).

1. Part 545 is added to read as follows:

PART 545—TALIBAN (AFGHANISTAN) SANCTIONS REGULATIONS

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Sec.

545.101 Relation of this part to other laws and regulations.

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Subpart E—Licenses, Authorizations and Statements of Licensing Policy

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545.506 Importation of certain gifts authorized.
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545.511 Registration of nongovernmental organizations for humanitarian or religious activities.
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Subpart H—Procedures

545.801 Procedures.
545.802 Delegation by the Secretary of the Treasury.

Subpart I—Paperwork Reduction Act

545.901 Paperwork Reduction Act notice.

Authority: 3 U.S.C. 301; 31 U.S.C. 321(b); 50 U.S.C. 1601–1651, 1701–1706; Pub. L. 101–410, 104 Stat. 890 (28 U.S.C. 2461 note); E.O. 13129, 64 FR 36759, 3 CFR, 1999 Comp., p. 200.

Subpart A—Relation of This Part to Other Laws and Regulations

§ 545.101 Relation of this part to other laws and regulations.

This part is separate from, and independent of, the other parts of this chapter, with the exception of part 501 of this chapter, the recordkeeping and reporting requirements and license application and other procedures of which apply to this part. Actions taken pursuant to part 501 of this chapter with respect to the prohibitions contained in this part are considered actions taken pursuant to this part. Differing foreign policy and national security circumstances may result in differing interpretations of similar language among the parts of this chapter. No license or authorization contained in or issued pursuant to those other parts authorizes any transaction prohibited by this part. No license or authorization contained in or issued pursuant to any other provision of law or regulation authorizes any transaction prohibited by this part. No license contained in or issued pursuant to this part relieves the involved parties from complying with any other applicable laws or regulations.

Subpart B—Prohibitions

§ 545.201 Prohibited transactions involving blocked property.

(a) Except as otherwise authorized by regulations, orders, directives, rulings, instructions, licenses, or otherwise, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, property or property interests of the following persons that are in the United States, that hereafter come within the United States, or that are or hereafter come within the possession or control of U.S. persons are blocked, and may not be transferred, paid, exported, withdrawn, or otherwise dealt in:

(1) The Taliban; and

(2) Persons determined by the Secretary of the Treasury, in consultation with the Secretary of State and the Attorney General:

(i) To be owned or controlled by, or to act for or on behalf of, the Taliban; or

(ii) To provide financial, material, or technological support for, or services in support of, any of the foregoing.

Note to paragraph (a) of § 545.201. Please refer to the appendices at the end of this chapter V for listings of persons designated pursuant to this section. Section 501.807 of this chapter V sets forth the procedures to be followed by persons seeking administrative reconsideration of their designation or who wish to assert that the circumstances resulting in designation no longer apply. Similarly, when a transaction results in the blocking of funds at a financial institution pursuant to this section and a party to the transaction believes the funds to have been blocked due to mistaken identity, that party may seek to have such funds unblocked pursuant to the administrative procedures set forth in § 501.806 of this chapter.

(b) Except as otherwise authorized, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, any transaction or dealing by U.S. persons or within the United States in property or interests in property blocked pursuant to paragraph (a) of this section is prohibited, including the making or receiving of any contribution of funds, goods, or services to or for the benefit of the Taliban or persons designated pursuant to § 545.201(a).

(c) Unless otherwise authorized by this part or by a specific license expressly referring to this section, any dealing in any security (or evidence thereof) held within the possession or control of a U.S. person and either registered or inscribed in the name of or known to be held for the benefit of any person whose property or interests in property are blocked pursuant to this section is prohibited. This prohibition includes but is not limited to the transfer (including the transfer on the books of any issuer or agent thereof), disposition, transportation, importation, exportation, or withdrawal of any such security or the endorsement or guaranty of signatures on any such security. This prohibition applies irrespective of the fact that at any time (whether prior to, on, or subsequent to January 11, 2001) the registered or inscribed owner of any such security may have or might appear to have assigned, transferred, or otherwise disposed of the security.

§ 545.202 Effect of transfers violating the provisions of this part.

(a) Any transfer after the effective date that is in violation of any provision of this part or of any regulation, order, directive, ruling, instruction, or license issued pursuant to this part, and that involves any property or interest in property blocked pursuant to § 545.201(a), is null and void and shall not be the basis for the assertion or recognition of any interest in or right, remedy, power, or privilege with respect to such property or property interests.

(b) No transfer before the effective date shall be the basis for the assertion or recognition of any right, remedy, power, or privilege with respect to, or any interest in, any property or interest in property blocked pursuant to § 545.201(a), unless the person with whom such property is held or maintained, prior to that date, had written notice of the transfer or by any written evidence had recognized such transfer.

(c) Unless otherwise provided, an appropriate license or other authorization issued by or pursuant to the direction or authorization of the Director of the Office of Foreign Assets Control before, during, or after a transfer shall validate such transfer or make it enforceable to the same extent that it would be valid or enforceable but for the provisions of the International Emergency Economic Powers Act, this part, and any regulation, order, directive, ruling, instruction, or license issued pursuant to this part.

(d) Transfers of property that otherwise would be null and void or unenforceable by virtue of the provisions of this section shall not be deemed to be null and void or unenforceable as to any person with whom such property was held or maintained (and as to such person only) in cases in which such person is able to establish to the satisfaction of the Director of the Office of Foreign Assets Control each of the following:

(1) Such transfer did not represent a willful violation of the provisions of this part by the person with whom such property was held or maintained;

(2) The person with whom such property was held or maintained did not have reasonable cause to know or suspect, in view of all the facts and circumstances known or available to such person, that such transfer required a license or authorization issued pursuant to this part and was not so licensed or authorized, or, if a license or authorization did purport to cover the transfer, that such license or authorization had been obtained by misrepresentation of a third party or withholding of material facts or was otherwise fraudulently obtained; and

(3) The person with whom such property was held or maintained filed with the Office of Foreign Assets Control a report setting forth in full the

circumstances relating to such transfer promptly upon discovery that:

(i) Such transfer was in violation of the provisions of this part or any regulation, ruling, instruction, license, or other direction or authorization issued pursuant to this part;

(ii) Such transfer was not licensed or authorized by the Director of the Office of Foreign Assets Control; or

(iii) If a license did purport to cover the transfer, such license had been obtained by misrepresentation of a third party or withholding of material facts or was otherwise fraudulently obtained.

Note to paragraph (d) of § 545.202: The filing of a report in accordance with the provisions of paragraph (d)(3) of this section shall not be deemed evidence that the terms of paragraphs (d)(1) and (d)(2) of this section have been satisfied.

(e) Unless licensed pursuant to this part, any attachment, judgment, decree, lien, execution, garnishment, or other judicial process is null and void with respect to any property in which on or since the effective date of § 545.201 there existed an interest of a person whose property or interests in property are blocked pursuant to § 545.201(a).

§ 545.203 Holding of funds in interest-bearing accounts; investment and reinvestment.

(a) Except as provided in paragraph (c) or (d) of this section, or as otherwise directed by the Office of Foreign Assets Control, any U.S. person holding funds, such as currency, bank deposits, or liquidated financial obligations, subject to § 545.201(a) shall hold or place such funds in a blocked interest-bearing account located in the United States.

(b)(1) For purposes of this section, the term *blocked interest-bearing account* means a blocked account:

(i) In a federally-insured U.S. bank, thrift institution, or credit union, provided the funds are earning interest at rates that are commercially reasonable; or

(ii) With a broker or dealer registered with the Securities and Exchange Commission under the Securities Exchange Act of 1934, provided the funds are invested in a money market fund or in U.S. Treasury bills.

(2) For purposes of this section, a rate is commercially reasonable if it is the rate currently offered to other depositors on deposits or instruments of comparable size and maturity.

(3) Funds held or placed in a blocked account pursuant to this paragraph (b) may not be invested in instruments the maturity of which exceeds 180 days. If interest is credited to a separate blocked account or subaccount, the name of the account party on each account must be the same.

(c) Blocked funds held in instruments the maturity of which exceeds 180 days at the time the funds become subject to § 545.201(a) may continue to be held until maturity in the original instrument, provided any interest, earnings, or other proceeds derived therefrom are paid into a blocked interest-bearing account in accordance with paragraph (b) or (d) of this section.

(d) Blocked funds held in accounts or instruments outside the United States at the time the funds become subject to § 545.201(a) may continue to be held in the same type of accounts or instruments, provided the funds earn interest at rates that are commercially reasonable.

(e) This section does not create an affirmative obligation for the holder of blocked tangible property, such as chattels or real estate, or of other blocked property, such as debt or equity securities, to sell or liquidate such property at the time the property becomes subject to § 545.201(a). However, the Office of Foreign Assets Control may issue licenses permitting or directing such sales in appropriate cases.

(f) Funds subject to this section may not be held, invested, or reinvested in a manner that provides immediate financial or economic benefit or access to persons whose property or interests in property are blocked pursuant to § 545.201(a), nor may their holder cooperate in or facilitate the pledging or other attempted use as collateral of blocked funds or other assets.

§ 545.204 Prohibited exportation, reexportation, sale, or supply of goods, software, technology, or services.

Except as otherwise authorized, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, the exportation, reexportation, sale, or supply, directly or indirectly, from the United States, or by a U.S. person, wherever located, of any goods, software, technology (including technical data), or services to the territory of Afghanistan controlled by the Taliban or to the Taliban or to persons whose property or interests in property are blocked pursuant to § 545.201 is prohibited.

§ 545.205 Prohibited importation of goods, software, technology, or services.

Except as otherwise authorized, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, the importation into the United States of any goods, software, technology, or services owned or controlled by the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 or from the territory of Afghanistan controlled by the Taliban is prohibited.

§ 545.206 Evasions; attempts; conspiracies.

(a) Except as otherwise authorized, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, any transaction by any U.S. person or within the United States on or after the effective date that evades or avoids, has the purpose of evading or avoiding, or attempts to violate any of the prohibitions set forth in this part is prohibited.

(b) Except as otherwise authorized, and notwithstanding any contract entered into or any license or permit granted prior to the effective date, any conspiracy formed for the purpose of engaging in a transaction prohibited by this part is prohibited.

§ 545.207 Expenses of maintaining blocked property; liquidation of blocked account.

(a) Except as otherwise authorized, and notwithstanding the existence of any rights or obligations conferred or imposed by any international agreement or contract entered into or any license or permit granted before 12:01 a.m., Eastern Daylight Time, July 6, 1999, all expenses incident to the maintenance of physical property blocked pursuant to § 545.201 shall be the responsibility of the owners or operators of such property, which expenses shall not be met from blocked funds.

(b) Property blocked pursuant to § 545.201 may, in the discretion of the Director, Office of Foreign Assets Control, be sold or liquidated and the net proceeds placed in a blocked interest-bearing account in the name of the owner of the property.

§ 545.208 Exempt transactions.

(a) *Personal communications.* The prohibitions contained in this part do not apply to any postal, telegraphic, telephonic, or other personal communication, which does not involve the transfer of anything of value.

(b) *Information or informational materials.* (1) The importation from any country and the exportation to any country of information or informational materials as defined in § 545.305, whether commercial or otherwise, regardless of format or medium of transmission, are exempt from the prohibitions of this part.

(2) This section does not exempt from regulation or authorize transactions related to information and informational materials not fully created and in existence at the date of the transactions, or to the substantive or artistic alteration or enhancement of informational materials, or to the provision of marketing and business consulting services. Such prohibited transactions include, but are not limited to, payment of advances for information and informational materials not yet created and completed (with the exception of prepaid subscriptions for widely-circulated magazines and other periodical publications); provision of services to market, produce or co-produce, create, or assist in the creation of information or informational materials; and, with respect to information or informational materials imported from persons whose property and interests in property are blocked pursuant to § 545.201 or from the territory of Afghanistan controlled by the Taliban, payment of royalties with respect to income received for enhancements or alterations made by U.S. persons to such information or informational materials.

(3) This section does not exempt or authorize transactions incident to the exportation of software subject to the Export Administration Regulations, 15 CFR parts 730–774, or to the exportation of goods, technology or software, or to the provision, sale, or leasing of capacity on telecommunications transmission facilities (such as satellite or terrestrial network connectivity) for use in the transmission of any data. The exportation of such items or services and the provision, sale, or leasing of such capacity or facilities to a person whose property or interests in property are blocked pursuant to § 545.201 are prohibited.

(c) *Travel.* The prohibitions contained in this part do not apply to transactions ordinarily incident to travel to or from any country, including exportation or importation of accompanied baggage for personal use, maintenance within any country including payment of living expenses and acquisition of goods or services for personal use, and arrangement or facilitation of such travel including nonscheduled air, sea, or land voyages.

(d) *Official Business.* The prohibitions contained in this part do not apply to transactions for the conduct of the official business of the United States Government or the United Nations by employees thereof.

(e) *Journalistic Activity.* The prohibitions contained in this part do not apply to transactions in the territory of Afghanistan controlled by the Taliban for journalistic activity by persons regularly employed in such capacity by a news-gathering organization.

(f) *Humanitarian donations.* The prohibitions contained in this part do not apply to donations by U.S. persons of articles, such as food, clothing, and medicine, intended to be used to relieve human suffering.

Subpart C—General Definitions

§ 545.301 Blocked account; blocked property.

The terms *blocked account* and *blocked property*, shall mean any account or property subject to the prohibitions in § 545.201 held in the name of the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201, or in which the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 have an interest, and with respect to which payments, transfers, exportations, withdrawals, or other dealings may not be made or effected except pursuant to an authorization or license from the Office of Foreign Assets Control expressly authorizing such action.

§ 545.302 Effective date.

The term *effective date* refers to the effective date of the applicable prohibitions and directives contained in this part which is 12:01 a.m., Eastern Daylight Time, on July 6, 1999.

§ 545.303 Entity.

The term *entity* means a partnership, association, corporation, or other organization, group, or subgroup.

§ 545.304 Importation into the United States.

(a) With respect to goods, software, or technology, the term *importation into the United States* means the bringing of any goods, software, or technology into the United States. However, with respect to goods, software or technology being transported by vessel, *importation into the United States* means the bringing of any goods or technology into the United States with the intent to unlade. See also § 545.404.

(b) With respect to services, the term *importation into the United States* means the receipt in the United States of services or receipt in the United States of the benefit of services wherever such services may be performed. The benefit of services is received in the United States if the services are:

(1) Performed on behalf of or for the benefit of a person located in the United States;

(2) Received by a person located in the United States;

(3) Received by a person located outside the United States on behalf of or for the benefit of an entity organized in the United States; or

(4) Received by an individual temporarily located outside the United States for the purpose of obtaining such services for use in the United States.

§ 545.305 Information or informational materials.

(a) For purposes of this part, the term *information or informational materials* includes, but is not limited to publications, films, posters, phonograph records, photographs, microfilms, microfiche, tapes, compact disks, CD ROMs, artworks, and news wire feeds.

Note to § 545.305(a). To be considered information or informational materials, artworks must be classified under chapter heading 9701, 9702, or 9703 of the Harmonized Tariff Schedule of the United States.

(b) The term *information* and *informational materials* with respect to United States exports does not include items:

(1) That were, as of April 30, 1994, or that thereafter become, controlled for export pursuant to section 5 of the Export Administration Act of 1979, 50 U.S.C. App. 2401–2420 (1979) (the ''EAA''), or section 6 of the EAA to the extent that such controls promote the nonproliferation or antiterrorism policies of the United States; or

(2) With respect to which acts are prohibited by 18 U.S.C. chapter 37.

§ 545.306 Interest.

Except as otherwise provided in this part, the term *interest* when used with respect to property (e.g., ''an interest in property'') means an interest of any nature whatsoever, direct or indirect.

§ 545.307 Licenses; general and specific.

(a) Except as otherwise specified, the term *license* means any license or authorization contained in or issued pursuant to this part.

(b) The term *general license* means any license or authorization the terms of which are set forth in subpart E of this part.

(c) The term *specific license* means any license or authorization not set forth in subpart E of this part but issued pursuant to this part.

Note to § 545.307: See § 501.801 of this chapter on licensing procedures.

§ 545.308 Person.

The term *person* means an individual or entity.

§ 545.309 Property; property interest.

The terms *property* and *property interest* include, but are not limited to, money, checks, drafts, bullion, bank deposits, savings accounts, debts, indebtedness, obligations, notes, guarantees, debentures, stocks, bonds, coupons, any other financial instruments, bankers acceptances, mortgages, pledges, liens or other rights in the nature of security, warehouse receipts, bills of lading, trust receipts, bills of sale, any other evidences of title, ownership or indebtedness, letters of credit and any documents relating to any rights or obligations thereunder, powers of attorney, goods, wares, merchandise, chattels, stocks on hand, ships, goods on ships, real estate mortgages, deeds of trust, vendors' sales agreements, land contracts, leaseholds, ground rents, real estate and any other interest therein, options, negotiable instruments, trade acceptances, royalties, book accounts, accounts payable, judgments, patents, trademarks or copyrights, insurance policies, safe deposit boxes and their contents, annuities, pooling agreements, services of any nature whatsoever, contracts of any nature whatsoever, and any other property, real, personal, or mixed, tangible or intangible, or interest or interests therein, present, future or contingent.

§ 545.310 The Taliban.

(a) For purposes of this part, the term *the Taliban* includes:

(1) The political/military entity headquartered in Kandahar, Afghanistan that as of July 4, 1999, exercised de facto control over the territory of Afghanistan, described in § 545.310(a);

(2) Its agencies and instrumentalities;

(3) The Taliban leaders listed in the Annex to Executive Order 13129 (see appendix A of this chapter) and such additional leaders as may be designated by the Secretary of State in consultation with the Secretary of the Treasury and the Attorney General in accordance with section 4(c) of Executive Order 13129; and

(4) Persons designated pursuant to § 545.201(a)(2).

Note to § 545.310. The Taliban is also known as the ''Taleban,'' ''Islamic Movement of Taliban,'' ''the Taliban Islamic Movement,'' ''Talibano Islami Tahrik,'' and ''Tahrike Islami'a Taliban.''

§ 545.311 Territory of Afghanistan controlled by the Taliban.

The term *territory of Afghanistan controlled by the Taliban* means the territory referred to as the ''Islamic Emirate of Afghanistan,'' known in Pashtun as ''de Afghanistan Islami Emarat'' or in Dari as ''Emarat Islami-e Afghanistan,'' including:

(a) As of July 4, 1999, the following provinces of the country of Afghanistan: Kandahar, Farah, Helmund, Nimruz, Herat, Badghis, Ghowr, Oruzghon, Zabol, Paktiha, Ghazni, Nangarhar, Lowgar, Vardan, Faryab, Jowlan, Balkh, and Paktika; and

(b) Thereafter, the description of the term *territory of Afghanistan controlled by the Taliban* may be modified by the Secretary of State in consultation with the Secretary of the Treasury and the Attorney General.

Note to § 545.311. The Secretary of State, in consultation with the Secretary of the Treasury and the Attorney General, has added the City of Kabul to the *territory of Afghanistan controlled by the Taliban.* (See Public Notice 3151 of October 21, 1999, 64 FR 58879, November 1, 1999).

§ 545.312 Transfer.

The term *transfer* means any actual or purported act or transaction, whether or not evidenced by writing, and whether or not done or performed within the United States, the purpose, intent, or effect of which is to create, surrender, release, convey, transfer, or alter, directly or indirectly, any right, remedy, power, privilege, or interest with respect to any property and, without limitation upon the foregoing, shall include the making, execution, or delivery of any assignment, power, conveyance, check, declaration, deed, deed of trust, power of attorney, power of appointment, bill of sale, mortgage, receipt, agreement, contract, certificate, gift, sale, affidavit, or statement; the making of any payment; the setting off of any obligation or credit; the appointment of any agent, trustee, or fiduciary; the creation or transfer of any lien; the issuance, docketing, filing, or levy of or under any judgment, decree, attachment, injunction, execution, or other judicial or administrative process or order, or the service of any garnishment; the acquisition of any interest of any nature whatsoever by reason of a judgment or decree of any foreign country; the fulfillment of any condition; the exercise of any power of appointment, power of attorney, or other power; or the acquisition, disposition, transportation, importation, exportation, or withdrawal of any security.

§ 545.313 United States.

The term *United States* means the United States, its territories and possessions, and all areas under the jurisdiction or authority thereof.

§ 545.314 U.S. financial institution.

The term *U.S. financial institution* means any U.S. entity (including its foreign branches) that is engaged in the business of accepting deposits, making, granting, transferring, holding, or brokering loans or credits, or purchasing or selling foreign exchange, securities, commodity futures or options, or procuring purchasers and sellers thereof, as principal or agent; including but not limited to, depository institutions, banks, savings banks, trust companies, securities brokers and dealers, commodity futures and options brokers and dealers, forward contract and foreign exchange merchants, securities and commodities exchanges, clearing corporations, investment companies, employee benefit plans, and U.S. holding companies, U.S. affiliates, or U.S. subsidiaries of any of the foregoing. This terms includes those branches, offices and agencies of foreign financial institutions that are located in the United States, but not such institutions' foreign branches, offices, or agencies.

§ 545.315 United States person; U.S. person.

The term *United States person* or *U.S. person* means any United States citizen, permanent resident alien, entity organized under the laws of the United States (including foreign branches), or any person in the United States.

Subpart D—Interpretations

§ 545.401 Reference to amended sections.

Except as otherwise specified, reference to any provision in or appendix to this part or chapter or to any regulation, ruling, order, instruction, direction, or license issued pursuant to this part refers to the same as currently amended.

§ 545.402 Effect of amendment.

Unless otherwise specifically provided, any amendment, modification, or revocation of any provision in or appendix to this part or chapter or of any order, regulation, ruling, instruction, or license issued by or under the direction of the Director of the Office of Foreign Assets Control does not affect any act done or omitted, or any civil or criminal suit or proceeding commenced or pending prior to such amendment, modification, or revocation. All penalties, forfeitures, and liabilities under any such order, regulation, ruling, instruction, or license continue and may be enforced as if such amendment, modification, or revocation had not been made.

§ 545.403 Transactions incidental to a licensed transaction authorized.

Any transaction ordinarily incident to a licensed transaction and necessary to give effect thereto is also authorized, except:

(a) A transaction involving a person whose property or interests in property are blocked pursuant to § 545.201, or involving a debit to a blocked account or a transfer of blocked property, not explicitly authorized within the terms of the license; and

(b) Distribution or leasing in the territory of Afghanistan controlled by the Taliban of any containers or similar goods owned or controlled by U.S. persons after the performance of transportation services to the territory of Afghanistan controlled by the Taliban.

§ 545.404 Transshipment or transit through the United States prohibited.

Except as otherwise specified:

(a) The prohibitions in §§ 545.201 and 545.204 apply to the importation into the United States, for transshipment or transit, of foreign goods which are intended or destined for the Taliban or the territory of Afghanistan controlled by the Taliban.

(b) The prohibitions in §§ 545.201 and 545.205 apply to the importation into the United States, for transshipment or transit to third countries, of goods owned or controlled by the Taliban or from the territory of Afghanistan controlled by the Taliban which are intended or destined for third countries.

(c) Goods, software, or technology in which the Taliban have an interest that are imported into or transshipped through the United States are blocked pursuant to § 545.201.

Note to § 545.404: See § 545.304 for the definition of the term *importation into the United States.*

§ 545.405 [Reserved].

§ 545.406 Exportation of services; performance of service contracts; legal services.

(a) The prohibition on transactions involving blocked property and the exportation of services contained in §§ 545.201 and 545.204 applies to services performed on behalf of the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 or where the benefit of such services is otherwise received in the territory of Afghanistan controlled by the Taliban, when such services are performed:

(1) In the United States;

(2) Outside the United States by a U.S. person, including by an overseas branch of an entity located in the United States.

(b) The benefit of services performed anywhere in the world on behalf of the Taliban, including persons whose property or interests in property are blocked pursuant to § 545.201, is presumed to have been received in the territory of Afghanistan controlled by the Taliban.

Note to § 545.406. See § 545.513 with regard to provision of certain legal services and § 545.516 with regard to the provision of certain financial services.

§ 545.407 Services performed in the territory of Afghanistan controlled by the Taliban.

The prohibitions on transactions involving blocked property and certain transactions or dealings in that property and the importation into the United States of services contained in §§ 545.201 and 545.205, respectively, apply to services performed in the territory of Afghanistan controlled by the Taliban or by the Taliban, wherever located, when the benefit of such services is received in the United States or by a U.S. person outside the United States. See § 545.304 for the definition of the term *importation into the United States* and a description of circumstances in which the benefit of services is considered to be received in the United States.

§ 545.408 Offshore transactions.

(a) The prohibitions contained in § 545.201 apply:

(1) To transactions by any U.S. person in a location outside the United States with respect to property in which the U.S. person knows, or has reason to know, that the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 have or have had an interest since the effective date; and

(2) With respect to goods, software, technology, or services which the U.S. person knows, or has reason to know, are from the territory of Afghanistan controlled by the Taliban.

(b) Prohibited transactions include, but are not limited to:

(1) Importation into or exportation from locations outside the United States of goods, software, technology or services owned or controlled by the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201; or

(2) Purchasing, selling, financing, swapping, insuring, transporting, lifting, storing, incorporating, transforming, brokering or otherwise dealing in such blocked goods, software, technology, or services.

(c) *Example.* A U.S. person may not, within the United States or abroad, purchase, sell, finance, insure, transport, act as a broker for the sale or transport of, or otherwise deal in goods (such as carpets, fruits, or nuts), owned or controlled by the Taliban or by persons whose property or interests in property are blocked pursuant to § 545.201 or which comes from the territory of Afghanistan controlled by the Taliban.

§ 545.409 Payments from blocked accounts to U.S. exporters and for other obligations prohibited.

No debits may be made to a blocked account to pay obligations to U.S. persons or other persons, including payment for goods, software, technology, or services exported prior to the effective date, except as authorized pursuant to this part.

§ 545.410 Acquisition of instruments including bankers acceptances.

No U.S. persons may acquire or deal in any obligation, including bankers acceptances and debt of or guaranteed by a person whose property or interests in property are blocked pursuant to § 545.201, in cases in which the documents evidencing the obligation indicate, or the U.S. person has actual knowledge, that the underlying transaction is in violation of §§ 545.201 and 545.204 through 545.206. This interpretation does not apply to obligations arising from an underlying transaction licensed or otherwise authorized pursuant to this part.

§ 545.411 Exportation to third countries; transshipments.

Except as otherwise specified, exportation of goods, software, or technology from the United States to third countries is prohibited if the exporter knows, or has reason to know, that the goods, software, or technology are intended for reexportation or transshipment to the Taliban, to persons whose property or interests in property are blocked pursuant to § 545.201, or to the territory of Afghanistan controlled by the Taliban, including passage through, or storage in, intermediate destinations.

§ 545.412 Release of goods originating in the territory of Afghanistan controlled by the Taliban from a bonded warehouse or foreign trade zone.

Section 545.205 does not prohibit the release from a bonded warehouse or foreign trade zone of goods originating in the territory of Afghanistan controlled by the Taliban imported into a bonded warehouse or foreign trade zone either prior to the effective date or in a transaction authorized pursuant to this part after the effective date.

Note to § 545.412: Property in which the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 have an interest may not be released unless authorized or licensed by the Office of Foreign Assets Control.

§ 545.413 Importation of goods from third countries; transshipments.

(a) Importation into the United States from third countries of goods containing raw materials or components originating in the territory of Afghanistan controlled by the Taliban is not prohibited if those raw materials or components have been incorporated into manufactured products or otherwise substantially transformed in a third country.

(b) Importation into the United States of goods originating in the territory of Afghanistan controlled by the Taliban that have been transshipped through a third country without being incorporated into manufactured products or otherwise substantially transformed in a third country is prohibited.

§ 545.414 Loans or extensions of credit.

(a) The prohibitions in §§ 545.201 and 545.204 apply to loans or extensions of credit to a person in the territory of Afghanistan controlled by the Taliban, including overdraft protection on checking accounts, and the unauthorized renewal or rescheduling of credits or loans in existence as of 12:01 a.m., Eastern Daylight Time, July 6, 1999, whether by affirmative action or operation of law.

(b) The prohibitions in §§ 545.201 and 545.204 apply to financial services including loans or credits extended in any currency.

§ 545.415 Payments from blocked accounts to U.S. exporters and for other obligations prohibited.

Pursuant to § 545.201, no debits may be made to a blocked account to pay obligations to U.S. persons or other persons, including payment for goods, technology or services exported prior to the effective date, except as authorized pursuant to this part.

§ 545.416 Termination and acquisition of an interest in blocked property.

(a) Whenever a transaction licensed or authorized by or pursuant to this part results in the transfer of property (including any property interest) away from a person whose property or interests in property are blocked pursuant to § 545.201, such property shall no longer be deemed to be property blocked pursuant to § 545.201, unless there exists in the property another interest that is blocked pursuant to § 545.201 or any other part of this chapter, the transfer of which has not been effected pursuant to license or other authorization.

(b) Unless otherwise specifically provided in a license or authorization issued pursuant to this part, if property (including any property interest) is transferred or attempted to be transferred to a person whose property or interests in property are blocked pursuant to § 545.201, such property shall be deemed to be property in which that person has an interest and therefore blocked.

§ 545.417 Setoffs prohibited.

A setoff against blocked property (including a blocked account), whether by a U.S. bank or other U.S. person, is a prohibited transfer under § 545.201 if effected after the effective date.

Subpart E—Licenses, Authorizations and Statements of Licensing Policy

§ 545.501 Effect of license or authorization.

(a) No license or other authorization contained in this part, or otherwise issued by or under the direction of the Director of the Office of Foreign Assets Control, authorizes or validates any transaction effected prior to the issuance of the license, unless specifically provided in such licenses or authorization.

(b) No regulation, ruling, instruction, or license authorizes any transaction prohibited under this part unless the regulation, ruling, instruction or license is issued by the Office of Foreign Assets Control and specifically refers to this part. No regulation, ruling, instruction, or license referring to this part shall be deemed to authorize any transaction prohibited by any provision of this chapter unless the regulation, ruling, instruction, or license specifically refers to such provision.

(c) Any regulation, ruling, instruction, or license authorizing any transaction otherwise prohibited under this part has the effect of removing a prohibition contained in this part from the transaction, but only to the extent specifically stated by its terms. Unless the regulation, ruling, instruction, or license otherwise specifies, such an authorization does not create any right, duty, obligation, claim, or interest in, or with respect to, any property which would not otherwise exist under ordinary principles of law.

§ 545.502 Exclusion from licenses.

The Director of the Office of Foreign Assets Control reserves the right to exclude any person, property, or transaction from the operation of any license or from the privileges conferred by any license. The Director of the Office of Foreign Assets Control also reserves the right to restrict the applicability of any license to particular persons, property, transactions, or classes thereof. Such actions are binding upon all persons receiving actual or constructive notice of the exclusions or restrictions.

§ 545.503 Payments and transfers to blocked accounts in U.S. financial institutions.

Any payment of funds or transfer of credit in which the Taliban or a person whose property or interests in property are blocked pursuant to § 545.201 has any interest, that comes within the possession or control of a U.S. financial institution, must be blocked in an account on the books of that financial institution. A transfer of funds or credit by a U.S. financial institution between blocked accounts in its branches or offices is authorized, provided that no transfer is made from an account within the United States to an account held outside the United States, and further provided that a transfer from a blocked account may only be made to another blocked account held in the same name.

Note to § 545.503. Please refer to § 501.603 of this chapter for mandatory reporting requirements regarding financial transfers. See also § 545.203 concerning the obligation to hold blocked funds in interest bearing accounts.

§ 545.504 Entries in certain accounts for normal service charges authorized.

(a) A U.S. financial institution is authorized to debit any blocked account held at that financial institution in payment or reimbursement for normal service charges owed it by the owner of that blocked account.

(b) As used in this section, the term *normal service charge* shall include charges in payment or reimbursement for interest due; cable, telegraph, internet, or telephone charges; postage costs; custody fees; small adjustment charges to correct bookkeeping errors; and, but not by way of limitation, minimum balance charges, notary and protest fees, and charges for reference books, photocopies, credit reports, transcripts of statements, registered mail, insurance, stationery and supplies, and other similar items.

§ 545.505 Importation of goods, software, or technology exported from the territory of Afghanistan controlled by the Taliban prior to July 6, 1999.

(a) Except for the persons and property described in paragraph (c) below, importation of goods, software,

or technology from the territory of Afghanistan controlled by the Taliban is authorized provided that:

(1) The applicant submits proof satisfactory to the U.S. Customs Service that the goods, software, or technology were exported from the territory of Afghanistan controlled by the Taliban before the effective date; and

(2) The importation is not otherwise prohibited by U.S. law.

Note to § 545.505(a). The general license in § 545.505(a) does not extend to services.

(b) The type of evidence that would constitute proof satisfactory to the U.S. Customs Service of the location of goods, software, or technology outside the territory of Afghanistan controlled by the Taliban before the effective date may vary depending on the facts of a particular case. However, independent corroborating documentary evidence issued and certified by a disinterested party normally will be required. This might include contracts, insurance documents, shipping documents, warehouse receipts, and appropriate customs documents, accompanied by a certification of an insurance agent, warehouse agent, or other appropriate person, identifying with particularity the goods sought to be imported and attesting that the goods concerned were located outside the territory of Afghanistan controlled by the Taliban at a time prior to the effective date. In general, affidavits, statements and other documents prepared by the applicant or other interested parties will not, by themselves, constitute satisfactory proof.

(c) The authorization in paragraph (a) above, shall not apply to any goods, software, or technology in which the Taliban or persons whose property or interests in property are blocked pursuant to § 545.201 have any interest.

§ 545.506 Importation of certain gifts authorized.

The importation into the United States of goods from the territory of Afghanistan controlled by the Taliban or from a person whose property or interests in property are blocked pursuant to § 545.201 is authorized for goods sent as gifts to persons provided that:

(a) The value of a gift is not more than $100 per recipient;

(b) The goods are of a type and in quantities normally given as gifts between individuals; and

(c) The goods are not controlled for chemical and biological weapons (CB), missile technology (MT), national security (NS), or nuclear proliferation (NP) (see Commerce Control List, 15 CFR part 774, supplement No. 1, of the Export Administration Regulations).

§ 545.507 Accompanied baggage authorized.

(a) Persons entering the United States directly or indirectly from the territory of Afghanistan controlled by the Taliban are authorized to import into the United States accompanied baggage normally incident to travel.

(b) Persons leaving the United States for the territory of Afghanistan controlled by the Taliban are authorized to export from the United States accompanied baggage normally incident to travel.

(c) For purposes of this section, the term *accompanied baggage normally incident to travel* includes only baggage that accompanies the traveler on the same aircraft, train, or vehicle, and includes only articles that are necessary for personal use incident to travel, that are not intended for any other person or for sale, and that are not otherwise prohibited from importation or exportation under applicable United States laws.

§ 545.508 Transactions related to telecommunications authorized.

All transactions ordinarily incident to the receipt or transmission of telecommunications involving the territory of Afghanistan controlled by the Taliban are authorized. This section does not authorize the provision, sale, or lease to the Taliban, or to persons whose property or interests in property are blocked pursuant to § 545.201, or to the territory of Afghanistan controlled by the Taliban, of telecommunications equipment or technology; nor does it authorize the provision, sale, or leasing of capacity on telecommunications transmission facilities (such as satellite or terrestrial network connectivity).

§ 545.509 Transactions related to mail authorized.

All transactions by U.S. persons, including payment and transfers to common carriers, incident to the receipt or transmission of mail between the United States and the territory of Afghanistan controlled by the Taliban are authorized, provided that mail is limited to personal communications not involving a transfer of anything of value.

§ 545.510 Importation of household and personal effects authorized.

The importation of household and personal effects originating in the territory of Afghanistan controlled by the Taliban, including baggage and articles for family use, of persons arriving in the United States, directly or indirectly from the territory of Afghanistan controlled by the Taliban, is authorized; to qualify, articles included in such effects must actually have been used abroad by such persons or by other family members arriving from the same foreign household, must not be intended for any other person or for sale, and must not be otherwise prohibited from importation.

§ 545.511 Registration of nongovernmental organizations for humanitarian or religious activities.

(a) Registration numbers may be issued on a case-by-case basis for the registration of nongovernmental organizations involved in humanitarian or religious activities in the territory of Afghanistan controlled by the Taliban, authorizing transactions by such organizations otherwise prohibited by this part, including the exportation of goods, software, technology or services to the territory of Afghanistan controlled by the Taliban and the transfer of funds to and from the territory of Afghanistan controlled by the Taliban for the purpose of relieving human suffering. Applicants for registration numbers must comply with the requirements of § 501.801(c).

(b) This section does not authorize transfers from blocked accounts.

Note to § 545.511: Registration does not excuse a U.S. person from compliance with other applicable U.S. laws governing the exportation or reexportation of U.S.-origin goods, software, or technology (including technical data). See, *e.g.,* the Export Administration Regulations administered by the U.S. Department of Commerce (15 CFR parts 730–774).

§ 545.512 Payment of obligations to U.S. persons authorized.

(a) The transfer of funds after the effective date by, through, or to any U.S. financial institution or other U.S. person solely for the purpose of payment of obligations owed to U.S. persons, including a payment of such obligations of persons whose property or interests in property are blocked pursuant to § 545.201, is authorized, provided that (1) the obligation arose prior to the effective date or is otherwise authorized or not prohibited pursuant to statute or the provisions of this part; (2) the payment requires no debit to a blocked account; and (3) the U.S. person is not blocked pursuant to this chapter V.

(b) A person receiving payment under this section may distribute all or part of that payment to any person, provided that any such payment to a person whose property or interests in property are blocked pursuant to § 545.201 must be to a blocked account in a U.S. financial institution.

Note to § 545.512: Please refer to § 501.603 of this chapter for mandatory reporting requirements regarding financial transfers. See also § 545.203 concerning the obligation to hold blocked funds in interest-bearing accounts.

§ 545.513 Provision of certain legal services authorized.

(a) The provision of the legal services set forth in paragraph (b) of this section to or on behalf of persons whose property or interests in property are blocked pursuant to § 545.201, and the exportation of such legal services to persons located in the territory of Afghanistan controlled by the Taliban or in circumstances in which the benefit is otherwise received in the territory of Afghanistan controlled by the Taliban, are authorized, provided that all receipts of payment of professional fees and reimbursement of incurred expenses must be specifically licensed.

(b) Specific licenses may be issued on a case-by-case basis authorizing receipt from unblocked sources of payment of professional fees and reimbursement of incurred expenses for the following legal services by U.S. persons to persons specified in paragraph (a) of this section:

(1) Provision of legal advice and counseling on the requirements of and compliance with the laws of any jurisdiction within the United States, provided that such advice and counseling is not provided to facilitate transactions in violation of this part;

(2) Representation of persons when named as defendants in or otherwise made parties to domestic U.S. legal, arbitration, or administrative proceedings;

(3) Initiation and conduct of domestic U.S. legal, arbitration, or administrative proceedings in defense of property interests subject to U.S. jurisdiction;

(4) Representation of persons before any federal or state agency with respect to the imposition, administration, or enforcement of U.S. sanctions against such persons; and

(5) Provision of legal services in any other context in which prevailing U.S. law requires access to legal counsel at public expense.

(c) The provision or exportation of any other legal services to persons whose property or interests in property are blocked pursuant to § 545.201 or who are located in the territory of Afghanistan controlled by the Taliban, not otherwise authorized in this part, requires the issuance of a specific license.

(d) Entry into a settlement agreement affecting property or interests in property or the enforcement of any lien, judgment, arbitral award, decree, or other order through execution, garnishment, or other judicial process purporting to transfer or otherwise alter or affect property or interests in property blocked pursuant to § 545.201 is prohibited unless specifically licensed in accordance with § 545.202(e).

§ 545.514 Payments for services rendered by the Taliban to aircraft.

(a) Specific licenses may be issued on a case-by-case basis for authorization of payments to the Taliban, to persons whose property or interests in property are blocked pursuant to § 545.201, or to persons within the territory of Afghanistan controlled by the Taliban of charges for services rendered in connection with the overflight of the territory of Afghanistan controlled by the Taliban or emergency landing in the territory of Afghanistan controlled by the Taliban by aircraft. Any such payments shall be made consistent with United Nations Security Council Resolution 1267.

(b) Specific licenses may be issued on a case-by-case basis for the exportation, reexportation, sale, or supply, directly or indirectly, of goods, software, technology, and services to ensure the safety of civil aviation and safe operation of U.S.-origin commercial passenger aircraft.

§ 545.515 Certain transactions related to patents, trademarks, and copyrights authorized.

(a) All of the following transactions in connection with patent, trademark, copyright or other intellectual property protection in the United States or Afghanistan are authorized:

(1) The filing and prosecution of any application to obtain a patent, trademark, copyright or other form of intellectual property protection, including importation of or dealing in services or payment for services from the Taliban, persons whose property or interests in property are blocked pursuant to § 545.201, or from persons within the territory of Afghanistan controlled by the Taliban connected to such intellectual property protection;

(2) The receipt of patent, trademark, copyright, or other form of intellectual property protection;

(3) The renewal or maintenance of a patent, trademark, copyright or other form of intellectual property protection; and

(4) The filing and prosecution of opposition or infringement proceedings with respect to a patent, trademark, copyright or other form of intellectual property protection, or the entrance of a defense to any such proceedings.

(b) Nothing in this section affects obligations under any other provision of law.

§ 545.516 Certain payments to or from the territory of Afghanistan controlled by the Taliban.

(a) United States financial institutions, as defined in § 545.314, are authorized to process transfers of funds to or from the territory of Afghanistan controlled by the Taliban if the transfer is covered in full by any of the following conditions and does not involve debiting a blocked account on the books of a U.S. financial institution:

(1) The transfer arises from an underlying transaction that has been authorized by a specific license, general license, or nongovernmental organization's registration number issued pursuant to this part; or

(2) The transfer arises from an underlying transaction that is not prohibited by or that is exempted from the prohibitions of this part, such as an exportation of information or informational materials to the territory of Afghanistan controlled by the Taliban, a travel-related remittance, or payment for the shipment of a donation of articles to relieve human suffering.

(b) With respect to transactions meeting the conditions of paragraph (a) of this section, before a United States depository institution initiates a payment on behalf of any U.S. non-bank customer, or credits a transfer to the account on its books of the ultimate beneficiary, the United States depository institution must determine that the underlying transaction is not prohibited by this part. To meet this requirement, a United States depository institution must either obtain a copy of the applicable specific license or nongovernmental organization's registration number or obtain a certification from the customer or beneficiary confirming that the transaction is authorized by a general license or not prohibited by this part. Such a certification will not meet the requirements of this section if the United States depository institution knows or has reason to know that any part of the certification is false.

§ 545.517 Authorization of emergency medical services.

The provision of nonscheduled emergency medical services in the United States to persons whose property or interests in property are blocked pursuant to § 545.201 is authorized, provided that all receipt of payment for such services must be specifically licensed.

§ 545.518 Investment and reinvestment of certain funds.

Subject to the requirements of § 545.203, U.S. financial institutions are authorized to invest and reinvest assets blocked pursuant to § 545.201, subject to the following conditions:

(a) The assets representing such investments and reinvestments are credited to a blocked account or subaccount which is held in the same name at the same U.S. financial institution, or within the possession or control of a U.S. person, but funds shall not be transferred outside the United States for this purpose;

(b) The proceeds of such investments and reinvestments shall not be credited to a blocked account or subaccount under any name or designation that differs from the name or designation of the specific blocked account or subaccount in which such funds or securities were held; and

(c) No immediate financial or economic benefit accrues (e.g., through pledging or other use) to persons whose property or interests in property are blocked pursuant to § 545.201.

§ 545.519 Payments and transfers authorized for goods and services exported to the territory of Afghanistan controlled by the Taliban prior to the effective date.

(a) Specific licenses may be issued on a case-by-case basis to permit payment involving an irrevocable letter of credit issued or confirmed by a U.S. bank, or a letter of credit reimbursement confirmed by a U.S. bank, from a blocked account or otherwise, of amounts owed to or for the benefit of a person with respect to goods, software, technology, or services exported prior to the effective date, directly or indirectly to the territory of Afghanistan controlled by the Taliban, or to third countries for an entity operated from territory of Afghanistan controlled by the Taliban, or for the benefit of the Taliban, where the license application presents evidence satisfactory to the Office of Foreign Assets Control that the exportation occurred prior to the effective date (such evidence may include, for example, the bill of lading, the air waybill, the purchaser's written confirmation of completed services, customs documents, and insurance documents).

(b) This section does not authorize the exportation of goods, software, technology, or services after the effective date pursuant to a contract entered into, or partially performed, prior to the effective date.

§ 545.520 Noncommercial personal remittances to or from the territory of Afghanistan controlled by the Taliban.

United States financial institutions, as defined in § 545.314, are authorized to process transfers of funds to or from the territory of Afghanistan controlled by the Taliban in cases in which the transfer involves a noncommercial, personal remittance, provided the beneficiary is not a person whose property or interests in property are blocked pursuant to § 545.201 or any other part of this chapter and the transfer is not by, to, or through a person whose property or interests in property are blocked pursuant to § 545.201 or any other part of this chapter V.

§ 545.521 Transactions related to U.S. citizens residing in the territory of Afghanistan controlled by the Taliban.

U.S. citizens who reside on a permanent basis in the territory of Afghanistan controlled by the Taliban are authorized to engage in transactions within the territory of Afghanistan controlled by the Taliban ordinarily incident to their routine and necessary maintenance and other personal living expenses.

Note to § 545.521. This provision does not authorize U.S. financial institutions, as defined in § 545.314, to transfer funds to persons whose property or interests in property are blocked pursuant to § 545.201.

§ 545.522 Operation of accounts.

The operation of an account in a U.S. financial institution, as defined in § 545.314, for a natural person in the territory of Afghanistan controlled by the Taliban, other than a person whose property or interests in property are blocked pursuant to § 545.201, is hereby authorized; however, such operation may not include the execution of transactions in support of transactions or activities prohibited by subpart B of this part.

§ 545.523 Extensions or renewals of letters of credit authorized.

(a) The extension or renewal, at the request of the account party, of a letter of credit or a standby letter of credit issued or confirmed by a U.S. financial institution is authorized, provided the transfer of funds is not made to a blocked account.

(b) Transactions conducted pursuant to this section must be reported to the Compliance Programs Division of the Office of Foreign Assets Control, U.S. Treasury Department, 1500 Pennsylvania Ave., NW., Annex, Washington, D.C. 20220, within 10 days after completion of the transaction.

§ 545.524 Extensions or renewals of loans.

Specific licenses may be issued on a case-by-case basis for rescheduling loans or otherwise extending the maturities of existing loans, and for charging fees or interest at commercially reasonable rates in connection therewith, provided that no new funds or credits are thereby transferred or extended to the Taliban, persons whose property or interests in property are blocked pursuant to § 545.201, or persons in the territory of Afghanistan controlled by the Taliban.

§ 545.525 Certain services relating to participation in various events and activities authorized.

(a) The importation into the United States or other dealing in services originating in the territory of Afghanistan controlled by the Taliban is authorized where such services are performed in the United States by a person from the territory of Afghanistan controlled by the Taliban who enters the United States on a visa issued by the State Department for the purpose of, or which services relate directly to, participation in a public conference, performance, exhibition or similar event, provided such services are consistent with that purpose.

(b) Persons otherwise qualified for a non-immigrant visa under categories A–3 and G–5 (attendants, servants and personal employees of aliens in the United States on diplomatic status), D (crewmen), F (students), I (information media representatives), J (exchange visitors), M (non-academic students), O and P (aliens with extraordinary ability, athletes, artists and entertainers), Q (international cultural exchange visitors), R (religious workers), or S (witnesses) are authorized to carry out in the United States those activities for which such a visa has been granted by the U.S. State Department.

(c) Persons otherwise qualified for a visa under categories E–2 (treaty investor), H–1b (temporary worker), or L (intra-company transferee) and all immigrant visa categories are authorized to carry out in the United States those activities for which such a visa has been granted by the U.S. State Department, provided that the persons are not coming to the United States to work as an agent, employee or contractor of the Taliban, or a person whose property or interests in property are blocked pursuant to § 545.201, or a business entity or other organization territory of Afghanistan controlled by the Taliban.

§ 545.526 Certain importations for diplomatic or official personnel authorized.

All transactions ordinarily incident to the importation into the United States of any goods, software, technology or services from the territory of Afghanistan controlled by the Taliban that are not for sale and are destined for official or personal use by personnel employed by the diplomatic missions of the Taliban to the United States and to international organizations located in the United States are authorized, unless the importation is otherwise prohibited by law.

§ 545.527 Diplomatic pouches.

All transactions in connection with the importation into the United States from the territory of Afghanistan controlled by the Taliban, or the exportation from the United States to the territory of Afghanistan controlled by the Taliban, of diplomatic pouches and their contents are authorized.

Subpart F—Reports

§ 545.601 Records and reports.

For provisions relating to required records and reports, see part 501, subpart C, of this chapter. Recordkeeping and reporting requirements imposed by part 501 of this chapter with respect to the prohibitions contained in this part are considered requirements arising pursuant to this part.

Subpart G—Penalties

§ 545.701 Penalties.

(a) Attention is directed to section 206 of the International Emergency Economic Powers Act (the ''Act'') (50 U.S.C. 1705), which is applicable to violations of the provisions of any license, ruling, regulation, order, direction, or instruction issued by or pursuant to the direction or authorization of the Secretary of the Treasury pursuant to this part or otherwise under the Act. Section 206 of the Act, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (Public Law 101–410, as amended, 28 U.S.C. 2461 note), provides that:

(1) A civil penalty not to exceed $11,000 per violation may be imposed on any person who violates or attempts to violate any license, order, or regulation issued under the Act;

(2) Whoever willfully violates or willfully attempts to violate any license, order, or regulation issued under the Act, upon conviction, shall be fined not more than $50,000, and if a natural person, may also be imprisoned for not more than 10 years; and any officer, director, or agent of any corporation who knowingly participates in such violation may be punished by a like fine, imprisonment, or both.

(b) The criminal penalties provided in the Act are subject to increase pursuant to 18 U.S.C. 3571.

(c) Attention is also directed to 18 U.S.C. 1001(a), which provides that whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device, a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any materially false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry shall be fined under title 18, United States Code, or imprisoned not more than five years, or both.

(d) Violations of this part may also be subject to relevant provisions of other applicable laws.

§ 545.702 Prepenalty notice.

(a) *When required.* If the Director of the Office of Foreign Assets Control has reasonable cause to believe that there has occurred a violation of any provision of this part or a violation of the provisions of any license, ruling, regulation, order, direction, or instruction issued by or pursuant to the direction or authorization of the Secretary of the Treasury pursuant to this part or otherwise under the International Emergency Economic Powers Act, and the Director determines that further proceedings are warranted, the Director shall notify the alleged violator of the agency's intent to impose a monetary penalty by issuing a prepenalty notice. The prepenalty notice shall be in writing. The prepenalty notice may be issued whether or not another agency has taken any action with respect to the matter.

(b) *Contents of notice*—(1) *Facts of violation.* The prepenalty notice shall describe the violation, specify the laws and regulations allegedly violated, and state the amount of the proposed monetary penalty.

(2) *Right to respond.* The prepenalty notice also shall inform the respondent of respondent's right to make a written presentation within the applicable 30 day period set forth in section 545.703 as to why a monetary penalty should not be imposed or why, if imposed, the monetary penalty should be in a lesser amount than proposed.

(c) *Informal settlement prior to issuance of prepenalty notice.* At any time prior to the issuance of a prepenalty notice, an alleged violator may request in writing that, for a period not to exceed sixty (60) days, the agency withhold issuance of the prepenalty notice for the exclusive purpose of effecting settlement of the agency's potential civil monetary penalty claims. In the event the Director grants the request, under terms and conditions within his discretion, the Office of Foreign Assets Control will agree to withhold issuance of the prepenalty notice for a period not to exceed 60 days and will enter into settlement negotiations of the potential civil monetary penalty claim.

§ 545.703 Response to prepenalty notice; informal settlement.

(a) *Deadline for response.* The respondent may submit a response to the prepenalty notice within the applicable 30 day period set forth in this paragraph. The Director may grant, at his discretion, an extension of time in which to submit a response to the prepenalty notice. The failure to submit a response within the applicable time period set forth in this paragraph shall be deemed to be a waiver of the right to respond.

(1) *Computation of time for response.* A response to the prepenalty notice must be postmarked or date-stamped by the U.S. Postal Service (or foreign postal service, if mailed abroad) or courier service provider (if transmitted to OFAC by courier) on or before the 30th day after the postmark date on the envelope in which the prepenalty notice was mailed. If the respondent refused delivery or otherwise avoided receipt of the prepenalty notice, a response must be postmarked or date-stamped on or before the 30th day after the date on the stamped postal receipt maintained at the Office of Foreign Assets Control. If the prepenalty notice was personally delivered to the respondent by a non-U.S. Postal Service agent authorized by the Director, a response must be postmarked or date-stamped on or before the 30th day after the date of delivery.

(2) *Extensions of time for response.* If a due date falls on a federal holiday or weekend, that due date is extended to include the following business day. Any other extensions of time will be granted, at the Director's discretion, only upon the respondent's specific request to the Office of Foreign Assets Control.

(b) *Form and method of response.* The response must be submitted in writing and may be handwritten or typed. The response need not be in any particular form. A copy of the written response may be sent by facsimile, but the original also must be sent to the Office of Foreign Assets Control Civil Penalties

Division by mail or courier and must be postmarked or date-stamped, in accordance with paragraph (a) of this section.

(c) *Contents of response.* A written response must contain information sufficient to indicate that it is in response to the prepenalty notice.

(1) A written response must include the respondent's full name, address, telephone number, and facsimile number, if available, or those of the representative of the respondent.

(2) A written response should either admit or deny each specific violation alleged in the prepenalty notice and also state if the respondent has no knowledge of a particular violation. If the written response fails to address any specific violation alleged in the prepenalty notice, that alleged violation shall be deemed to be admitted.

(3) A written response should include any information in defense, evidence in support of an asserted defense, or other factors that the respondent requests the Office of Foreign Assets Control to consider. Any defense or explanation previously made to the Office of Foreign Assets Control or any other agency must be repeated in the written response. Any defense not raised in the written response will be considered waived. The written response also should set forth the reasons why the respondent believes the penalty should not be imposed or why, if imposed, it should be in a lesser amount than proposed.

(d) *Default.* If the respondent elects not to submit a written response within the time limit set forth in paragraph (a) of this section, the Office of Foreign Assets Control will conclude that the respondent has decided not to respond to the prepenalty notice. The agency generally will then issue a written penalty notice imposing the penalty proposed in the prepenalty notice.

(e) *Informal settlement.* In addition to or as an alternative to a written response to a prepenalty notice, the respondent or respondent's representative may contact the Office of Foreign Assets Control as advised in the prepenalty notice to propose the settlement of allegations contained in the prepenalty notice and related matters. However, the requirements set forth in paragraph (f) of this section as to oral communication by the representative must first be fulfilled. In the event of settlement at the prepenalty stage, the claim proposed in the prepenalty notice will be withdrawn, the respondent will not be required to take a written position on allegations contained in the prepenalty notice, and the Office of Foreign Assets Control will make no final determination as to whether a violation occurred. The amount accepted in settlement of allegations in a prepenalty notice may vary from the civil penalty that might finally be imposed in the event of a formal determination of violation. In the event no settlement is reached, the time limit specified in paragraph (a) of this section for written response to the prepenalty notice remains in effect unless additional time is granted by the Office of Foreign Assets Control.

(f) *Representation.* A representative of the respondent may act on behalf of the respondent, but any oral communication with the Office of Foreign Assets Control prior to a written submission regarding the specific allegations contained in the prepenalty notice must be preceded by a written letter of representation, unless the prepenalty notice was served upon the respondent in care of the representative.

§ 545.704 Penalty imposition or withdrawal.

(a) *No violation.* If, after considering any response to the prepenalty notice and any relevant facts, the Director of the Office of Foreign Assets Control determines that there was no violation by the respondent named in the prepenalty notice, the Director shall notify the respondent in writing of that determination and of the cancellation of the proposed monetary penalty.

(b) *Violation.* (1) If, after considering any written response to the prepenalty notice, or default in the submission of a written response, and any relevant facts, the Director of the Office of Foreign Assets Control determines that there was a violation by the respondent named in the prepenalty notice, the Director is authorized to issue a written penalty notice to the respondent of the determination of violation and the imposition of the monetary penalty.

(2) The penalty notice shall inform the respondent that payment or arrangement for installment payment of the assessed penalty must be made within 30 days of the date of mailing of the penalty notice by the Office of Foreign Assets Control.

(3) The penalty notice shall inform the respondent of the requirement to furnish the respondent's taxpayer identification number pursuant to 31 U.S.C. 7701 and that such number will be used for purposes of collecting and reporting on any delinquent penalty amount.

(4) The issuance of the penalty notice finding a violation and imposing a monetary penalty shall constitute final agency action. The respondent has the right to seek judicial review of that final agency action in federal district court.

§ 545.705 Administrative collection; referral to United States Department of Justice.

In the event that the respondent does not pay the penalty imposed pursuant to this part or make payment arrangements acceptable to the Director of the Office of Foreign Assets Control within 30 days of the date of mailing of the penalty notice, the matter may be referred for administrative collection measures by the Department of the Treasury or to the United States Department of Justice for appropriate action to recover the penalty in a civil suit in a federal district court.

Subpart H—Procedures

§ 545.801 Procedures.

For license application procedures and procedures relating to amendments, modifications, or revocations of licenses; administrative decisions; rulemaking; and requests for documents pursuant to the Freedom of Information and Privacy Acts (5 U.S.C. 552 and 552a), see part 501, subpart D, of this chapter.

§ 545.802 Delegation by the Secretary of the Treasury.

Any action that the Secretary of the Treasury is authorized to take pursuant to Executive Order 13129 of July 4, 1999 (64 FR 36759, July 7, 1999) and any further Executive orders relating to the national emergency declared in Executive Order 13129 may be taken by the Director of the Office of Foreign Assets Control or by any other person to whom the Secretary of the Treasury has delegated authority so to act.

Subpart I—Paperwork Reduction Act

§ 545.901 Paperwork Reduction Act notice.

For approval by the Office of Management and Budget (''OMB'') under the Paperwork Reduction Act of 1995 (44 U.S.C. 3507) of information collections relating to recordkeeping and reporting requirements, licensing procedures (including those pursuant to statements of licensing policy), and other procedures, see § 501.901 of this chapter. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by OMB.

Dated: December 26, 2000.

R. Richard Newcomb,

Director, Office of Foreign Assets Control.

Approved: January 2, 2001.

Elisabeth A. Bresee,

Assistant Secretary (Enforcement), Department of the Treasury.

[FR Doc. 01–690 Filed 1–5–01; 3:53 pm]

BILLING CODE 4810–25–P

Federal Register

Thursday,
January 11, 2001

Part V

Department of Commerce

National Telecommunications and Information Administration

Technology Opportunities Program; Notice

DEPARTMENT OF COMMERCE

National Telecommunications and Information Administration

[Docket No. 981203295–0355–05]

RIN 0660–ZA06; CFDA 11.552

Technology Opportunities Program

AGENCY: National Telecommunications and Information Administration, Commerce.

ACTION: Notice of availability of funds.

SUMMARY: The National Telecommunications and Information Administration (NTIA) issues this Notice describing the conditions under which applications will be received under the Technology Opportunities Program (TOP) and how NTIA will determine which applications it will fund. TOP promotes the widespread availability and use of digital network technologies in the public and non-profit sectors.

To accomplish this objective, TOP provides matching grants to state, local, and tribal governments and non-profit entities for model projects that demonstrate innovative uses of digital network technologies in underserved communities. TOP projects address specific challenges and realize opportunities in such areas as lifelong learning, community and economic development, government and public services, safety, health, and culture and the arts.

DATES: Complete applications for the Fiscal Year 2001 TOP grant program must be mailed or hand-carried to the address indicated below and received by NTIA no later than 8:00 P.M. EST, March 22, 2001.

ADDRESSES: Applications must be mailed to: Technology Opportunities Program National Telecommunications and Information Administration U.S. Department of Commerce 1401 Constitution Avenue, NW. HCHB, Room 4092 Washington, DC 20230 or hand-delivered to: Technology Opportunities Program National Telecommunications and Information Administration U.S. Department of Commerce HCHB, Room 1874 1401 Constitution Avenue, NW. Washington, DC 20230. Room 1874 is located at entrance #10 on 15th Street NW., between Pennsylvania and Constitution Avenues.

FOR FURTHER INFORMATION, CONTACT: Stephen J. Downs, Director of the Technology Opportunities Program. Telephone: 202–482–2048; fax: 202–501–5136; e-mail: top@ntia.doc.gov.

SUPPLEMENTARY INFORMATION:

Authority

Consolidated Appropriations Act for FY2001, Pub. L. 106–553.

Eligible Organizations

All non-profit entities (including, but not limited to, non-profit community-based organizations, non-profit health care providers, public health institutions, schools, libraries, museums, colleges, universities, public safety providers) and state, local, and tribal governments are eligible to apply. Although individuals and for-profit organizations are not eligible to apply, they are encouraged to participate as project partners.

Funding Availability

Approximately $42.5 million is available for federal assistance. A small amount of funds that have been deobligated from grants awarded in previous fiscal years may also be available for Fiscal Year 2001 grants. Based on past experience, NTIA expects this year's grant round to be very competitive. In Fiscal Year 2000, NTIA received over 660 applications collectively requesting more than $270 million in federal funds. From these applications, the Department of Commerce announced 35 awards totaling $13.9 million in federal funds.

Award Amounts

An applicant may request up to a total of $900,000 in funds from NTIA. TOP expects the federal amounts awarded to range from $200,000 to $900,000, with an average of approximately $500,000.

Matching Funds Requirements

Grant recipients under this program will be required to provide matching funds toward the total project cost. Applicants must document their capacity to provide matching funds. Matching funds may be in the form of cash or in-kind contributions.

NTIA will provide up to 50 percent of the total project cost, unless the applicant can document extraordinary circumstances warranting a grant of up to 75 percent. Grant funds under this program are usually released in direct proportion to local matching funds utilized and documented as having been expended.

Generally, federal funds may not be used as matching funds, except as provided by federal statute. If you plan to use funds from a federal agency, you should contact the federal agency that administers the funds in question and obtain documentation from that agency's Office of General Counsel to support the use of federal funds for matching purposes.

Completeness of Application

TOP will initially review all applications to determine whether all required elements are present and clearly identifiable. The required elements are listed and described in the Guidelines for Preparing Applications—Fiscal Year 2001. Each of the required elements must be present and clearly identified. Failure to do so may result in rejection of the application.

Application Deadline

As noted above, complete applications for the Fiscal Year 2001 TOP grant program must be received by NTIA no later than 8 p.m. est, March 22, 2001. A postmark date is not sufficient. Applications which have been provided to a delivery service on or before March 21, 2001, with ''delivery guaranteed'' before 8 p.m. on March 22, 2001, will be accepted for review if the applicant can document that the application was provided to the delivery service with delivery to the address listed above guaranteed prior to the closing date and time. Applications will not be accepted via facsimile machine transmission or electronic mail. NTIA anticipates that it will take approximately six months to complete the review of applications and make final funding decisions.

Program Funding Priorities

While access to computers and the Internet among underserved populations is increasing, effective use of digital network technologies continues to lag in underserved communities and the organizations that serve them.[1] Across the country, various groups of people and geographic communities face technological, economic, physical, linguistic, or cultural barriers that limit or prevent their use of digital network technologies or vital services. Through TOP, NTIA provides underserved communities with opportunities to overcome these barriers and explore the benefits that emerging digital network technologies offer.

TOP projects demonstrate creative uses of digital networks to address challenges in the public and non-profit sectors. All funded projects must be interactive in that they allow end users to share information with each other or gain access to information on an on-demand basis, as opposed to a one-way

[1] Recent NTIA-sponsored reports, including Falling Through the Net, Toward Digital Inclusion and Historically Black Colleges and Universities: An Assessment of Networking and Connectivity, provide more details on the levels of access among specific communities. These reports are accessible via NTIA's home page at http://www.ntia.doc.gov.

or broadcast basis.[2] TOP supported projects must also involve communication and new partnerships among multiple unaffiliated organizations or enable direct, interactive communication between an organization and the public it serves.

Fundamental to any TOP project is the applicant's vision of how to use networks to address specific challenges and realize opportunities in such areas as lifelong learning, community and economic development, government and public services, safety, health, and culture and the arts. Rather than simply requesting funds to build capacity or upgrade existing equipment, each application should describe a project that identifies specific problems, proposes creative solutions, and postulates measurable outcomes.

As a national program, TOP emphasizes innovation, learning, and diffusion of new ideas and practical knowledge. Each TOP-supported project must be innovative in the sense that it represents a departure from how other communities and groups across the country are using network technology to address pressing challenges. Each TOP project should yield new insights into how best to use network technology and offer opportunities to learn what works well and what doesn't. Because these grants will serve as national models for other communities, NTIA expects each project to include provisions for thorough evaluations that will provide valid and reliable data as well as valuable lessons learned to be shared with others interested in the project.

For the FY 2001 grant competition, TOP is especially interested in projects that involve:

- Broadband technologies that bring very high-speed communications directly to end users;
- Mobile wireless communication technologies that offer end users greater flexibility in how, where, and when they access information;
- Empowering end users to move beyond passive information consumption to become valued contributors to the development, modification, and expansion of shared information resources; [3]
- Emerging data sharing techniques that facilitate the seamless and secure exchange of information across organizational boundaries; and
- Sustainable strategies to pool community demand to support the widespread availability of digital network services.

As in past years, TOP is also especially interested in projects developed by smaller, locally-based organizations that both serve and represent underserved communities across the nation. For example, these organizations may include but are not limited to: community-based organizations; small non-profits; colleges and universities serving rural communities; Minority Serving Institutions (Historically Black Colleges and Universities, Hispanic Serving Institutions, and Tribal Colleges and Universities); and organizations representing Empowerment Zones and Enterprise Communities.

In previous fiscal years, NTIA supported planning projects whose primary goal was to develop strategies for the development of network technologies. The emphasis for Fiscal Year 2001 is on projects that develop and use network technologies. NTIA will, however, support projects that incorporate some planning activities as part of the proposed project.

Limitations on Project Scope

Each TOP project is expected to include a range of activities that support project development, implementation, and evaluation. However, TOP will not support projects whose primary purpose is to develop hardware or software, to provide training on the use of the network technologies, or to build voice-based systems. Details on these restrictions are discussed below.

(1) *Hardware or Software Development Projects.* Some projects may require limited software development or the customization or modification of existing software or hardware in order to meet particular end-user requirements or to enable the exchange of information across networks. However, the creation of a software or hardware product cannot be a project's primary purpose.

(2) *Training Projects.* While TOP does consider training to be an essential aspect of most projects, TOP will not support projects whose primary purpose is to provide training in the use of software applications, Internet use, or other use of network technologies.

(3) *Voice-based Systems.* Two-way, interactive voice networks are an important element of the existing network systems. Voice as a means for conveying information and voice input tools play critical roles in ensuring people with disabilities have access to network technology. However, TOP will not support projects whose primary purpose is to either build or install voice-based communication networks such as call centers, two-way radio networks, enhanced-911 and 311 systems, or 800 MHZ radio systems.

Review Criteria

Reviewers will review and rate each application using the following criteria. The relative weights of each criterion are identified in parentheses.

1. Project Purpose (20%)

Each application should describe a clearly defined project that focuses on underserved communities. In this criterion, reviewers will judge each application on (1) the overall design of the project and (2) the degree to which it provides opportunities for underserved communities.

In assessing the project design, reviewers will examine the degree to which the applicant clearly: Defines the problem(s) within the community to be served and describes its severity; proposes creative and practical means of addressing the community's problem(s) employing digital network technologies; and identifies anticipated outcomes and that are both realistic and measurable. Reviewers will also assess the degree to which an applicant convincingly links the three major elements—problem(s), solution(s), and outcome(s).

Reviewers will assess the degree to which the project targets underserved communities and populations, and the degree to which the proposed project will address the circumstances and challenges (such as poverty, low literacy, disabilities, high unemployment, low educational achievement, high crime rate, poor health status, etc.) they face.

2. Innovation (20%)

Reviewers will assess innovation by examining both the technology to be used and the application of technology in a particular setting, to serve a particular population, or to solve a particular problem. TOP defines innovation broadly. For example, projects that involve imaginative partnerships, the introduction of new business processes designed to offer more effective services, untested strategies for overcoming access barriers, or new techniques that transform inter-organizational relationships can all be considered innovative. TOP encourages applicants to experiment with leading edge technologies. It is, however, the creativity behind the application of the

[2] An ''end user'' is an individual who directly utilizes the network technology.

[3] For example, once isolated communities now use Internet technology to collect and express their histories; children have become agents of community change as they have used network technology to collect information, provide analysis, and contribute to the public policy dialogue in their communities; and citizens are exploring the creation of databases which enrich the resources made available by local and state governments.

technology to meet community needs that ultimately determines the level of innovation.

Using their experience in their respective fields, reviewers will examine each project in a national context and evaluate (1) how an application compares with, complements, and improves on the existing base of knowledge and project practices and (2) what insight(s) the proposed project could add to what is known about using digital network technology as a solution to problems in its particular field.

3. Diffusion Potential (20%)

The innovations and approaches to be demonstrated in any proposed project should contain the potential to be diffused broadly throughout the country. NTIA expects that each awarded project will serve as a model for other communities to follow.

To assess this potential for diffusion, reviewers will consider four factors:

(1) The degree to which the problem identified by the applicant is common to many communities;

(2) The relative advantage of the project's innovations over established approaches to addressing the specified problems;

(3) The ease of replication and adaptation, based on considerations such as cost and complexity; and

(4) The applicant's plans and budget resources dedicated to disseminate actively the knowledge gained from the project's successes and failures.

4. Project Feasibility (15%)

In assessing the feasibility of each application, reviewers will focus on six issues: the technical approach, the qualifications of the project staff, the proposed budget, the implementation schedule, plans for protecting privacy, and the applicant's plan for sustaining the project beyond the grant period.

(1) In assessing technical approach, reviewers will examine the degree to which the proposed system would work and operate with other systems; technological alternatives that have been considered; designs for system maintenance and periodic upgrades; and plans project expansion. Applicants are expected to make use of existing infrastructure and commercially available telecommunications services, unless extraordinary circumstances require the construction of new network facilities.

(2) In assessing the qualifications of the project team, reviewers will assess the applicant and its partners to determine if they have the resources, expertise, and experience necessary to undertake, evaluate, and complete the project and disseminate results within the proposed period.

(3) Reviewers will analyze the budget in terms of clarity and cost-effectiveness. The proposed budget should be appropriate to the tasks proposed and sufficiently detailed so that reviewers can easily understand the relationship of items in the budget to the project narrative.

(4) Reviewers also will assess the degree to which the implementation process is comprehensive, reasonable, and can be completed in the proposed time frame.

(5) Reviewers will evaluate the applicant's plans to safeguard the privacy of the project's end users and others affected by the project.

(6) Finally, reviewers will examine the applicant's strategies to sustain the project after the completion of the grant.

5. Community Involvement (15%)

Each application will be rated on the overall level and breadth of community involvement in the development and implementation of the proposed project. Reviewers will:

(1) Analyze the applicant's partnerships to ensure that they include linkages among unaffiliated organizations (from the public, non-profit, or private sectors) as an ongoing and integral part of project planning and implementation. TOP considers partners to be organizations that supply cash or in-kind resources and/or play an active role in the planning and implementation of the project;

(2) Examine the steps the applicant has taken to include and sustain the involvement of a variety of community stakeholders. Reviewers will look for evidence of demand, from the community, the end users, and the potential beneficiaries, for the services proposed by the project; and

(3) Consider the degree of attention paid to the needs, skills, working conditions, and living environments of the targeted end users. Reviewers will consider the extent to which applicants involve representatives from a broad range of potential users in both the design and implementation of the project and consider the varying degrees of abilities of all end users, including individuals with disabilities. Reviewers will also assess the degree to which the project addresses barriers which limit a community's or a group's access to digital network technologies. Finally, reviewers will assess the applicant's plans for training end users and upgrading their skills.

6. Evaluation (10%)

Each application will be rated on its proposed plans for evaluating the project. Reviewers will assess the extent to which the applicant's research or evaluation design: (1) Provides for continuous feedback for project planning, implementation, review and revision; (2) addresses the problems, solutions, and anticipated outcomes described in the project purpose and yields valid and reliable findings; (3) captures lessons learned and sufficient descriptive data so that others may easily adapt and replicate the project; and (4) meets TOP's requirements for an independent evaluation as described in the ''Reporting Requirements'' section of this Notice.

Reviewers will examine:

(1) The research design and methodology;

(2) Evaluation questions, data collection, and data analysis plans;

(3) The qualifications of any staff or external evaluators working on the evaluation; and

(4) The allocation of resources for implementing the evaluation and reporting project findings.

Eligible Costs

Eligible Costs. Allowable costs incurred under approved projects shall be determined in accordance with applicable federal cost principles, *i.e.*, OMB Circular A–21, A–87, A–122, or appendix E of 45 CFR part 74. If included in the approved project budget, TOP will allow costs for personnel; fringe benefits; computer hardware, software, and other end-user equipment; telecommunication services and related equipment; consultants, evaluators, and other contractual services; travel; rental of office equipment, furniture, and space; and supplies. All costs must be reasonable and directly related to the project.

Indirect Costs. The total dollar amount of the indirect costs proposed in an application under this program must not exceed the indirect cost rate negotiated and approved by a cognizant federal agency.

Ineligible Costs

Costs associated with the construction or major renovation of buildings are not eligible. While costs for the construction of new network facilities are eligible costs, applicants are expected to make use of existing infrastructure and commercially available telecommunications services. Only under extraordinary circumstances will the construction of new network facilities be approved.

Costs of the professional services, such as instruction, counseling, or medical care, provided via a network supported through this program are not eligible.

Note that costs that are ineligible for TOP support may not be included as part of the applicant's matching fund contribution.

In addition, the Appropriations for Fiscal Year 2001 places restrictions on eligible costs for applicants that are recipients of Universal Service Fund discounts and applicants receiving assistance from the Department of Justice's Regional Information Sharing Systems Program as part of the project costs.

This statute provides:

That notwithstanding any other provision of law, no entity that receives telecommunications services at preferential rates under section 254(h) of the Act (47 U.S.C. 254(h)) or receives assistance under the regional information sharing systems grant program of the Department of Justice under part M of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3796h) may use funds under a grant under this heading to cover any costs of the entity that would otherwise be covered by such preferential rates or such assistance, as the case may be.[4]

Accordingly, recipients of the above-described preferential rates or assistance are prohibited from including any costs that would be covered by such preferential rates or assistance in their proposed TOP grant budget. More details on this restriction can be found in the Guidelines for Preparing Applications—Fiscal Year 2001.

Award Period

Successful applicants will have between 12 and 36 months to complete their projects. While the completion time will vary depending on the complexity of the project, NTIA has found that most grant recipients require at least two years to complete and fully evaluate their projects. Accordingly, NTIA encourages applicants to propose projects that last two to three years.

Selection Process

The selection process will last approximately six months and involves four stages:

(1) During the first stage, each eligible application will be reviewed by a panel of outside readers, who have demonstrated expertise in both the programmatic and technological aspects of the application. The review panels will evaluate applications according to the review criteria provided in this notice and make non-binding written recommendations to the program.

(2) Upon completion of the external review process, program staff may analyze applications as necessary. Program staff analysis will be based on the degree to which a proposed project meets the program's funding scope as described in the section entitled ''Limitations on Project Scope''; the eligibility of costs and matching funds included in an application's budget; and the extent to which an application complements or duplicates projects previously funded or under consideration by NTIA or other federal programs.[5] The analysis of program staff will be provided to the TOP Director in writing.

The TOP Director then prepares and presents a slate of recommended grant awards to the Office of Telecommunications and Information Applications' (OTIA) Associate Administrator for review and approval.[6] The Director's recommendations and the Associate Administrator's review and approval will take into account the following selection factors:

1. The evaluations of the outside reviewers;

2. The analysis of program staff;

3. The degree to which the proposed grants meet the program's priorities as described in the section entitled ''Program Funding Priorities';

4. The geographic distribution of the proposed grant awards;

5. The variety of technologies and diversity of uses of the technologies employed by the proposed grant awards;

6. The provision of access to and use of digital network technologies by rural communities and other underserved groups;

7. Avoidance of redundancy and conflicts with the initiatives of other federal agencies; and,

8. The availability of funds.

(3) Upon approval by the OTIA Associate Administrator, the Director's recommendations will then be presented to the Selecting Official, the NTIA Administrator. The NTIA Administrator selects the applications to be negotiated for possible grant award taking into consideration the Director's recommendations and the degree to which the slate of applications, taken as a whole, satisfies the selection factors described above and the program's stated purposes as set forth in the section entitled ''Program Purposes.''

(4) After applications have been selected in this manner, negotiations will take place between TOP staff and the applicant. These negotiations are intended to resolve any differences that exist between the applicant's original request and what TOP proposes to fund, and if necessary, to clarify items in the application. Not all applicants who are contacted for negotiation will necessarily receive a TOP award. Final selections made by the Administrator will be based upon the recommendations by the Director and the OTIA Associate Administrator and the degree to which the slate of applications, taken as a whole, satisfies the program's stated purposes as set forth in the section entitled ''Program Purposes,'' upon the conclusion of negotiations.

Use of Program Income

Applicants are advised that any program income generated by a proposed project is subject to special conditions. Anticipated program income must be documented appropriately in the project budget. In addition, should an application be funded, unanticipated program income must be reported to TOP, and the budget for the project must be renegotiated to reflect receipt of this program income. Program income means gross income earned by the recipient that is either directly generated by a supported activity, or earned as a result of the award. In addition, federal policy prohibits any recipient or subrecipient receiving federal funds from the use of equipment acquired with these funds to provide services to non-federal outside organizations for a fee that is less than private companies charge for equivalent services. This prohibition does not apply to services provided to outside organizations at no cost.

Policy on Sectarian Activities

Applicants are advised that on December 22, 1995, NTIA issued a notice in the **Federal Register** on its policy with regard to sectarian activities. Under NTIA's policy, while religious activities cannot be the essential thrust of a grant, an application will not be ineligible where sectarian activities are only incidental or attenuated to the overall project purpose for which funding is requested. Applicants for whom this policy may be relevant should read the policy that was published in the **Federal Register** at 60 FR 66491, Dec. 22, 1995.

[4] Consolidated Appropriations Act for FY2001, Pub. L. 106–553.

[5] See discussion of ''Eligible Costs'' and ''Matching Funds Requirements'' in this Notice.

[6] The Office of Telecommunication and Information Applications is the division of the National Telecommunications and Information Administration that supervises NTIA's grant awards programs.

Reporting Requirements

To ensure compliance with federal regulations and collect systemic evaluation data on each project, successful TOP applicants have a number of basic reporting requirements once they are awarded a grant. At project outset, TOP grantees provide detailed baseline information on the project objectives, goals, partners, and populations served. Each quarter, grantees provide financial reports and updates on project activities. At project completion, TOP grantees must also provide a closeout report. Finally, because evaluation results play such a critical role in helping other organizations learn about what works well and what does not, each TOP-supported project will provide NTIA a final evaluation report. To ensure the validity of the findings, the final evaluation report must be completed by an independent evaluator or team of evaluators who are not in a direct reporting relationship with the applicant.[7] TOP will make copies of the final evaluation report available to the public.

Waiver Authority

It is the general intent of NTIA not to waive any of the provisions set forth in this Notice. However, under extraordinary circumstances and when it is in the best interest of the federal government, NTIA, upon its own initiative or when requested, may waive the provisions in this Notice. Waivers may only be granted for requirements that are discretionary and not mandated by statute. Any request for a waiver must set forth the extraordinary circumstances for the request and be included in the application or sent to the address provided in the **ADDRESSES** section above. NTIA will not consider a request to waive the application deadline for an application until the application has been received.

Other Information

Electronic Information. Information about NTIA and TOP, including this document and the *Guidelines for Preparing Applications—Fiscal Year 2001*, can be retrieved electronically via the Internet using the World Wide Web at http://www.ntia.doc.gov/otiahome/top/. This document can be provided in alternate formats, including braille. If you need assistance please contact TOP at 202–482–2048 or top@ntia.doc.gov.

In order to facilitate the diffusion of ideas generated by the grant round and opportunities for other potential funders to identify promising projects, TOP will provide a copy of each application's executive summary and contact information on its home page.

Application Forms. Standard Forms 424 (OMB Approval Number 0348–0044), Application for Federal Assistance; 424A (OMB Approval Number 0348–0043), Budget Information—Non-Construction Programs; and 424B (OMB Approval Number 0348–0040), Assurances—Non-Construction Programs, (Rev 4–92), and other Department of Commerce forms shall be used in applying for financial assistance. These forms are included in the *Guidelines for Preparing Applications—Fiscal Year 2001*. TOP requests one original and five copies of the application. Applicants for whom the submission of five copies presents financial hardship may submit one original and two copies of the application. Notwithstanding any other provision of law, no person is required to respond to nor shall a person 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 currently valid OMB control number. In addition, all applicants are required to submit a copy of their application to their state Single Point of Contact (SPOC) offices, if they have one. For information on contacting state SPOC offices, refer to the *Guidelines for Preparing Applications—Fiscal Year 2001*.

Because of the high level of public interest in projects supported by TOP, the program anticipates receiving requests for copies of successful applications. Applicants are hereby notified that the applications they submit are subject to the Freedom of Information Act. To assist NTIA in making disclosure determinations, applicants may identify sensitive information and label it ''confidential.''

Type of Funding Instrument. The funding instrument for awards under this program shall be a grant.

Federal Policies and Procedures. Recipients and subrecipients are subject to all applicable federal laws and federal and Department of Commerce policies, regulations, and procedures applicable to federal financial assistance awards. Information on Department of Commerce Policies can be found on the Internet through the Department of Commerce's Office of Executive Assistance Management (OEAM).

Pre-Award Activities. If an applicant incurs any project costs prior to the project start date negotiated at the time the award is made, it does so solely at its own risk of not being reimbursed by the government. Applicants are hereby notified that, notwithstanding any oral or written assurance that they may have received, there is no obligation on the part of the Department of Commerce to cover pre-award costs.

No Obligation for Future Funding. If an application is selected for funding, the Department of Commerce has no obligation to provide any additional future funding in connection with that award. Renewal of an award to increase funding or extend the period of performance is at the total discretion of the Department of Commerce.

Past Performance. Unsatisfactory performance of an applicant under prior federal financial assistance awards may result in that applicant's proposal not being considered for funding.

Delinquent Federal Debts. No award of federal funds shall be made to an applicant who has an outstanding delinquent federal debt until:

1. The delinquent account is paid in full;

2. A negotiated repayment schedule is established and at least one payment is received; or

3. Other arrangements satisfactory to the Department of Commerce are made.

Purchase of American Made Products. Applicants are hereby notified that any equipment or products authorized to be purchased with funding provided under this program must be American-made to the maximum extent feasible.

Name Check Review. All non-profit applicants are subject to a name check review process. Name checks are intended to reveal if any key individuals associated with the applicant have been convicted of or are presently facing criminal charges such as fraud, theft, perjury, or other matters that significantly reflect on the applicant's management, honesty, or financial integrity.

Primary Applicant Certifications. All primary applicants must submit a completed Form CD–511, ''Certifications Regarding Debarment, Suspension and Other Responsibility Matters; Drug-Free Workplace Requirements and Lobbying,'' and the following explanations are hereby provided:

1. Nonprocurement Debarment and Suspension—Prospective participants (as defined at 15 CFR part 26, section 105) are subject to 15 CFR part 26, ''Nonprocurement Debarment and

[7] In large institutions, such as universities, colleges, and foundations, an independent evaluator can include a representative from departments not associated with the applicant. In addition, TOP's requirement for having a grantee have an independent evaluator develop the final evaluation report does not preclude an applicant from conducting the evaluation in conjunction with an independent evaluator.

Suspension'' and the related section of the certification form prescribed above applies;

2. Drug-Free Workplace—Grantees (as defined at 15 CFR part 26, section 605) are subject to 15 CFR part 26, subpart F, ''Government wide Requirements for Drug-Free Workplace (Grants)'' and the related section of the certification form prescribed above applies;

3. Anti-Lobbying—Persons (as defined at 15 CFR part 28, section 105) are subject to the lobbying provisions of 31 U.S.C. 1352, ''Limitation on use of appropriated funds to influence certain federal contracting and financial transactions,'' and the lobbying section of the certification form prescribed above applies to applications/bids for grants, cooperative agreements, and contracts for more than $100,000, and loans and loan guarantees for more than $150,000, or the single family maximum mortgage limit for affected programs, whichever is greater; and

4. Anti-Lobbying Disclosure—Any applicant that has paid or will pay for lobbying in connection with a covered federal action, such as the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement using any funds must submit an SF–LLL, ''Disclosure of Lobbying Activities'' (OMB Control Number 0348–0046), as required under 15 CFR part 28, Appendix B.

Lower Tier Certifications. Recipients shall require applicants/bidders for subgrants, contracts, subcontracts, or other lower tier covered transactions at any tier under the award to submit, if applicable, a completed Form CD–512, ''Certifications Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions and Lobbying'' and disclosure form SF–LLL, ''Disclosure of Lobbying Activities.'' Form CD–512 is intended for the use of recipients and should not be transmitted to DOC. SF–LLL submitted by any tier recipient or subrecipient should be submitted to DOC in accordance with the instructions contained in the award document.

False Statements. A false statement on an application is grounds for denial or termination of funds and grounds for possible punishment by a fine or imprisonment as provided in 18 U.S.C. § 1001.

Intergovernmental Review. Applications under this program are subject to Executive Order 12372, ''Intergovernmental Review of Federal Programs.'' It has been determined that this notice is a ''not significant'' rule under Executive Order 12866.

Gregory L. Rohde,

Assistant Secretary for Communications and Information.

[FR Doc. 01–657 Filed 1–10–01; 8:45 am]

BILLING CODE 3510–60–U

Federal Register

Thursday,
January 11, 2001

Part VI

Department of Defense
General Services Administration
National Aeronautics and Space Administration

48 CFR Parts 8 and 52
Federal Acquisition Regulation; Acquisition of Helium; Proposed Rule

DEPARTMENT OF DEFENSE

GENERAL SERVICES ADMINISTRATION

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Parts 8 and 52

[FAR Case 2000–008]

RIN: 9000–AJ09

Federal Acquisition Regulation; Acquisition of Helium

AGENCIES: Department of Defense (DoD), General Services Administration (GSA), and National Aeronautics and Space Administration (NASA).

ACTION: Proposed rule.

SUMMARY: The Civilian Agency Acquisition Council and the Defense Acquisition Regulations Council (Councils) are proposing to amend the Federal Acquisition Regulation (FAR) to implement the Helium Privatization Act of 1996 and associated changes to the U.S. Department of the Interior's regulations regarding its helium program.

DATES: Interested parties should submit comments in writing on or before March 12, 2001 to be considered in the formulation of a final rule.

ADDRESSES: Submit written comments to: General Services Administration, FAR Secretariat (MVR), 1800 F Street, NW, Room 4035, ATTN: Laurie Duarte, Washington, DC 20405.

Submit electronic comments via the Internet to: farcase.2000–008@gsa.gov

Please submit comments only and cite FAR case 2000–008 in all correspondence related to this case.

FOR FURTHER INFORMATION CONTACT: The FAR Secretariat, Room 4035, GS Building, Washington, DC, 20405, at (202) 501–4755 for information pertaining to status or publication schedules. For clarification of content, contact Ms. Linda Nelson, Procurement Analyst, at (202) 501–1900. Please cite FAR case 2000–008.

SUPPLEMENTARY INFORMATION:

A. Background

This proposed rule revises FAR subpart 8.5 and the clause at 52.208–8 to implement the U.S. Department of the Interior's final rule regarding helium contracts that was published in the **Federal Register** at 63 FR 66760, December 3, 1998.

The proposed rule—

- Requires agencies and their contractors and subcontractors to purchase major helium requirements from Federal helium suppliers;
- Changes the definitions;
- Eliminates the requirement for certain contractors and subcontractors to submit helium forecasts; and
- Establishes the requirement that contractors and subcontractors under contracts with a major helium requirement must report purchases of helium from Federal helium suppliers.

The rule is written using plain language in accordance with the White House memorandum, Plain Language in Government Writing, dated June 1, 1999.

This is not a significant regulatory action and, therefore, was not subject to review under Section 6(b) of Executive Order 12866, Regulatory Planning and Review, dated September 30, 1993. This rule is not a major rule under 5 U.S.C. 804.

B. Regulatory Flexibility Act

The Councils do not expect this proposed rule to have a significant economic impact on a substantial number of small entities within the meaning of the Regulatory Flexibility Act, 5 U.S.C. 601, *et seq.*, because the rule eliminates the information requirement for submitting helium forecasts and replaces it with a similar information requirement to report helium purchases. We estimate that the net change is zero. An Initial Regulatory Flexibility Analysis has, therefore, not been performed. We invite comments from small businesses and other interested parties. The Councils will consider comments from small entities concerning the affected FAR parts 8 and 52 in accordance with 5 U.S.C. 610. Interested parties must submit such comments separately and should cite 5 U.S.C. 601, *et seq.* (FAR case 2000–008), in correspondence.

C. Paperwork Reduction Act

The Paperwork Reduction Act does apply; however, the proposed changes to the FAR do not materially change existing information collection requirements under OMB Control Number 9000–0113, which was previously approved by the Office of Management and Budget under 44 U.S.C. 3501, *et seq.*

List of Subjects in 48 CFR parts 8 and 52

Government procurement.

Dated: January 4, 2001.

Al Matera,

Acting Director, Federal Acquisition Policy Division.

Therefore, DoD, GSA, and NASA propose that 48 CFR parts 8 and 52 be amended as set forth below:

1. The authority citation for 48 CFR parts 8 and 52 continues to read as follows:

Authority: 40 U.S.C. 486(c); 10 U.S.C. chapter 137; and 42 U.S.C. 2473(c).

PART 8—REQUIRED SOURCES OF SUPPLIES AND SERVICES

§ 8.500 [Amended]

2. Amend section 8.500 by removing ''30 CFR Parts 601 and 602'' and add ''43 CFR part 3195'' in its place.

3. Amend section 8.501 as follows:

(a) Remove the definitions ''Bureau helium'' and ''Helium requirement forecast'';

(b) Amend the definition ''Bureau of Land Management'' by removing ''Field'' and after the word ''Street'' adding '' Suite 500'';

(c) Add the definition ''Federal helium supplier''; and

(d) Revise the definition ''Major helium requirement''; The added and revised text reads as follows:

8.501 Definitions.

* * * * *

Federal helium supplier means a private helium vendor that has an in-kind crude helium sales contract with the Bureau of Land Management (BLM) and that is on the BLM Amarillo Field Office's Authorized List of Federal Helium Suppliers available via the Internet at http://www.nm.blm.gov/www/amfo/amfo_home.html.

Major helium requirement means an estimated refined helium requirement greater than 200,000 standard cubic feet (scf) (measured at 14.7 pounds per square inch absolute pressure and 70 degrees Fahrenheit temperature) of gaseous helium or 7510 liters of liquid helium delivered to a helium use location per year.

4. Revise section 8.502 to read as follows:

8.502 Policy.

Agencies and their contractors and subcontractors must purchase major helium requirements from Federal helium suppliers, to the extent that supplies are available.

5. Revise sections 8.504 and 8.505 to read as follows:

8.504 Procedures.

The contracting officer must forward the following information to the Bureau

of Land Management within 45 days of the close of each fiscal quarter—

(a) The name of any company that supplied a major helium requirement;

(b) The amount of helium purchased;

(c) The delivery date(s); and

(d) The location where the helium was used.

8.505 Contract clause.

Insert the clause at 52.208–8, Required Sources for Helium and Helium Usage Data, in solicitations and contracts if it is anticipated that performance of the contract involves a major helium requirement.

PART 52—SOLICITATION PROVISIONS AND CONTRACT CLAUSES

6. Revise section 52.208–8 to read as follows:

52.208–8 Required Sources for Helium and Helium Usage Data.

As prescribed in 8.505, insert the following clause:

Required Sources for Helium and Helium Usage Data (Date)

(a) *Definitions.* As used in this clause—

Bureau of Land Management means the—Department of the Interior, Bureau of Land Management, Helium Operations 801 South Fillmore Street, Suite 500, Amarillo, TX 79101–3545.

Federal helium supplier means a private helium vendor that has an in-kind crude helium sales contract with the Bureau of Land Management (BLM) and that is on the BLM Amarillo Field Offices Authorized List of Federal Helium Suppliers available via the Internet at http://www.nm.blm.gov/www/amfo/amfo_home.html.

Major helium requirement means an estimated refined helium requirement greater than 200,000 standard cubic feet (scf) (measured at 14.7 pounds per square inch absolute pressure and 70 degrees Fahrenheit temperature) of gaseous helium or 7510 liters of liquid helium delivered to a helium use location per year.

(b) *Requirements*—(1) Contractors must purchase major helium requirements from Federal helium suppliers, to the extent that supplies are available.

(2) The Contractor shall provide to the Contracting Officer the following data within 10 days after the Contractor or subcontractor receives a delivery of helium from a Federal helium supplier—

(i) The name of the supplier;

(ii) The amount of helium purchased;

(iii) The delivery date(s); and

(iv) The location where the helium was used.

(c) *Subcontracts.* The Contractor shall insert this clause, including this paragraph (c), in any subcontract or order that involves a major helium requirement. (End of clause)

[FR Doc. 01–652 Filed 1–10–01; 8:45 am]

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Federal Register

Thursday,

January 11, 2001

Part VII

Department of Transportation

Federal Motor Carrier Safety Administration

49 CFR Parts 385, 390, 398

Federal Motor Carrier Safety Regulations; Definition of Commercial Motor Vehicle (CMV); Requirements for Operators of Small Passenger-Carrying CMVs; Final Rule and Proposed Rule

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Part 390

[Docket Nos. FMCSA–97–2858 and 99–5710 (formerly FHWA–97–2858 and 99–5710)]

RINs 2126–AA51 and 2126–AA44 [formerly RINs 2125–AE22 and 2125–AE60]

Federal Motor Carrier Safety Regulations; Definition of Commercial Motor Vehicle (CMV); Requirements for Operators of Small Passenger-Carrying CMVs

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Final rule.

SUMMARY: The FMCSA is amending the Federal Motor Carrier Safety Regulations (FMCSRs) to adopt the statutory definition of a commercial motor vehicle (CMV) found at 49 U.S.C. 31132. The FMCSA is also amending the FMCSRs to require that motor carriers operating CMVs designed or used to transport between 9 and 15 passengers (including the driver) for compensation file a motor carrier identification report, mark their CMVs with a USDOT identification number, and maintain an accident register. The agency is imposing these requirements to monitor the operational safety of motor carriers operating small passenger-carrying vehicles for compensation. This rulemaking is in response to the Transportation Equity Act for the 21st Century (TEA–21).

DATES: This rule is effective on February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Mr. Larry W. Minor, Office of Bus and Truck Standards and Operations, (202) 366–4009, Federal Motor Carrier Safety Administration, 400 Seventh Street, SW., Washington, D.C. 20590–0001; or Mr. Charles E. Medalen, Office of the Chief Counsel, HCC–20, (202) 366–1354, Federal Highway Administration, 400 Seventh Street, SW., Washington, D.C. 20590–0001. 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

Internet users may access all comments that were submitted to the Docket Clerk, U.S. DOT Dockets, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001, in response to previous rulemaking notices concerning the dockets referenced at the beginning of this notice by using the universal resource locator (URL): *http://dms.dot.gov.* It is available 24 hours each day, 365 days each year. Please follow the instructions online for more information and help.

An electronic copy of this document may be downloaded using a modem and suitable communications software from the Government Printing Office's Electronic Bulletin Board Service at (202) 512–1661. Internet users may 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/naray.*

Background

Section 204 of the Motor Carrier Safety Act of 1984 (MCSA) (Pub. L. 98–554, Title II, 98 Stat. 2832, at 2833) defined a ''commercial motor vehicle'' as one having a gross vehicle weight rating (GVWR) of 10,001 pounds or more; designed to transport more than 15 passengers, including the driver; or transporting hazardous materials in quantities requiring the vehicle to be placarded. This definition, codified at 49 U.S.C. 31132(1), was the basis for the regulatory definition of a CMV in 49 CFR 390.5, which determines the jurisdictional limits and applicability of most of the FMCSRs. The Senate Committee on Commerce, Science and Transportation, in a report which accompanied the MCSA stated: ''The 10,000-pound limit, which is in the current BMCS [Bureau of Motor Carrier Safety, now the FMCSA] regulations, is proposed to focus enforcement efforts and because small vans and pickup trucks are more analogous to automobiles than to medium and heavy commercial vehicles, and can best be regulated under State automobile licensing, inspection, and traffic surveillance procedures.'' S. Rep. No. 98–424, at 6–7 (1984), reprinted in 1984 U.S.C.C.A.N. 4785, 4790–91.

Although the MCSA demonstrated congressional intent to focus the applicability of the FMCSRs on larger vehicles, Congress did not repeal section 204 of the Motor Carrier Act of 1935 (Chapter 498, 49 Stat. 543, 546). This statute, now codified at 49 U.S.C. 31502, authorizes the FMCSA to regulate the safety of all for-hire motor carriers of passengers and property, and private carriers of property without respect to the weight or passenger capacity of the vehicles they operate.

When the Congress enacted the Commercial Motor Vehicle Safety Act of 1986 (CMVSA) (Pub. L. 99–570, Title XII, 100 Stat. 3207–170) to require implementation of a single, classified commercial driver's license program, it also limited the motor vehicles subject to the program to those designed to transport more than 15 passengers, including the driver (now codified at 49 U.S.C. 31301(4)(B) with slightly different wording). This, too, revealed the congressional policy of applying available Federal motor carrier safety resources to larger vehicles.

The ICC Termination Act of 1995 (ICCTA) (Pub. L. 104–88, 109 Stat. 803, 919) changed the MCSA's definition of a commercial motor vehicle. As amended, 49 U.S.C. 31132(1) defined a commercial motor vehicle, in part, as a vehicle that is ''designed or used to transport passengers for compensation, but exclud(es) vehicles providing taxicab service and having a capacity of not more than 6 passengers and not operated on a regular route or between specified places; (or) is designed or used to transport more than 15 passengers, including the driver, and is not used to transport passengers for compensation.'' The ICCTA authorized, but did not require, the FHWA to change the FMCSRs; accordingly, the agency did not incorporate the amended language into the CMV definition in 49 CFR 390.5. The agency notes that the ICCTA included the phrase ''designed or used'' in specifying the passenger-carrying threshold for the FMCSRs. This change will make the FMCSRs applicable based upon the number of passengers in the vehicle or the number of designated seating positions, whichever is greater. In other words, a bus designed to carry 13 people but actually carrying 18 would be subject to the FMCSRs.

Section 4008(a)(2) of the TEA–21 (Pub. L. 105–178, 112 Stat. 107, June 9, 1998) again amended the passenger-vehicle component of the CMV definition in 49 U.S.C. 31132(1). Section 4008 also changed the weight threshold in the CMV definition by adding ''gross vehicle weight'' (GVW) to the previous ''gross vehicle weight rating'' (GVWR). The agency may now exercise its jurisdiction based on the GVW or GVWR, whichever is greater. A vehicle with a GVWR of 9,500 pounds that was loaded to 10,500 pounds GVW would therefore be subject to the FMCSRs if it was operating in interstate commerce. Commercial motor vehicle is now defined (in 49 U.S.C 31132) to mean a self-propelled or towed vehicle used on the highways in interstate commerce to transport passengers or property, if the vehicle—

(A) Has a gross vehicle weight rating or gross vehicle weight of at least 10,001 pounds, whichever is greater;

(B) Is designed or used to transport more than 8 passengers (including the driver) for compensation;

(C) Is designed or used to transport more than 15 passengers, including the driver, and is not used to transport passengers for compensation; or

(D) Is used in transporting material found by the Secretary of Transportation to be hazardous under section 5103 of this title and transported in a quantity requiring placarding under regulations prescribed by the Secretary under section 5103.

Under section 4008(b) of the TEA–21, operators of the CMVs defined by section 31132(1)(B) would automatically become subject to the FMCSRs one year after the date of enactment of TEA–21, if they were not already covered, ''except to the extent that the Secretary [of Transportation] determines, through a rulemaking proceeding, that it is appropriate to exempt such operators of commercial motor vehicles from the application of those regulations.''

The FMCSA views section 4008(b) of the TEA–21 as a mandate either to impose the FMCSRs on previously unregulated smaller capacity vehicles, or to exempt through a rulemaking proceeding some, or all of the operators of such vehicles. Although the House Conference Report (H.R. Conf. Rep. No. 104–422(1995)) on the ICCTA definitional change directed the agency not to impose on the States (as grant conditions under the Motor Carrier Safety Assistance Program (MCSAP)) the burden of regulating a new population of carriers covered by the definition, no such restriction is included in TEA–21 or its legislative history. The mandate of the TEA–21 is thus stricter than that of the ICCTA.

On December 9, 1999, the President signed the Motor Carrier Safety Improvement Act of 1999 (MCSIA) (Pub. L. 106–159, 113 Stat. 1748). Section 212 of the MCSIA requires that the FMCSA make its safety regulations applicable to: (1) Commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks. The rulemaking to implement section 212 must be completed by December 9, 2000.

Elsewhere in today's **Federal Register**, the FMCSA published a notice of proposed rulemaking to amend the FMCSRs to implement section 212 of the MCSIA. The proposal addresses the safety oversight of camionetas operations and other van operations that have been determined to pose a serious safety risk and, consequently, focuses on many concerns raised by the Congress, the commercial passenger carrier industry, and the commenters in this proceeding. The remainder of this preamble focuses on the issues related to bringing closure to the rulemaking dockets identified at the top of this document.

Summary of Advance Notice of Proposed Rulemaking

On August 5, 1998 (63 FR 41766), the FHWA published an advance notice of proposed rulemaking (ANPRM) to announce that the agency was considering amending the FMCSRs in response to section 4008(a) of the TEA–21, to seek information about the potential impact of the TEA–21 definition, and to request public comment on the question of whether any class of vehicles should be exempted. The agency also requested comment on whether the term ''for compensation'' may be interpreted to distinguish among the types of van services currently in existence.

The agency received 733 comments in response to the ANPRM. The commenters included State and local government agencies, transit authorities, vanpool organizations, vanpool members, universities, trade associations, members of the Congress, and private citizens. Most (more than 720) of the commenters were opposed to making the FMCSRs applicable to the operation of small passenger-carrying CMVs. However, several commenters believed it is necessary to regulate these vehicles and, in certain cases, identified what they believe are the specific safety issues section 4008(a) of the TEA–21 was intended to resolve.

The majority of the commenters opposed to the rulemaking were organizers, members of vanpools, State and local agencies, and vanpool associations that believe implementing the definition of a passenger vehicle in section 4008(a) of the TEA–21 would adversely impact vanpool participation by imposing more stringent standards on drivers of these vehicles. Some of the commenters argued that there was no data to support imposing the FMCSRs on the operators of small CMVs, while others emphasized the adverse impacts that the rulemaking could have on transportation providers for elderly and disabled citizens.

Of the 733 comments submitted in response to the agency's ANPRM, only a few expressed support for implementing section 4008(a). The reasons for supporting the adoption of the revised definition of a CMV varied from the belief that highway safety would be improved if the commercial driver's license and controlled substances and alcohol testing rules were applicable to drivers of small passenger-carrying vehicles, to the belief that applying the safety regulations to these vehicles would improve school bus transportation. None of the commenters in support of regulating small passenger-carrying vehicles believed implementing section 4008(a) of the TEA–21 would result in adverse impacts to those businesses.

Summary of Interim Final Rule and Notice of Proposed Rulemaking

On September 3, 1999 (64 FR 48510), the FHWA published an interim final rule to adopt the statutory definition of a CMV found at 49 U.S.C. 31132. The interim final rule also exempted the operation of vehicles designed or used to transport more than 8 passengers (including the driver) for compensation, from all the FMCSRs for six months. On the same day, the agency published a notice of proposed rulemaking (NPRM) (64 FR 48518) to require that these motor carriers file a motor carrier identification report, mark their CMVs with a USDOT identification number and certain other information (*i.e.,* name or trade name and address of the principal place of business), and maintain an accident register.

Discussion of Comments to the Interim Final Rule and NPRM

There were nine comments in response to the interim final rule. The commenters were: the American Bus Association (ABA); the American Public Transit Association (APTA); the Colorado Department of Public Safety (Colorado DPS); the International Taxicab and Livery Association (ITLA); Greyhound Lines, Inc. (Greyhound); the National Funeral Directors Association (NFDA); the National Limousine Association, Inc. (NLA); the San Mateo County Transit District; and the Texas Department of Public Safety (Texas DPS).

There were 20 comments in response to the notice of proposed rulemaking. The commenters were: Mr. Ignacio Almada, a concerned college student; the Amalgamated Transit Union (ATU); the ABA; the American Car Rental Association (ACRA); Mr. E.A. Brown, a concerned citizen; Casa de Proyecto Libertad; the Commercial Vehicle Safety Alliance (CVSA); the Colorado DPS; Farmworker Justice Fund, Inc. (FJF); Greyhound; the ITLA; the Iowa Department of Transportation; Mr. Rick Farris, a concerned citizen; the League of United Latin American Citizens (LULAC); the National Automobile Dealers Association (NADA); the National Council of La Raza (NCLR); the NFDA; the NLA; Mr. Evan Nacherlilla, a concerned college student; and the Texas DPS.

Comments in Support of Making the FMCSRs Applicable to Operators of Small CMVs

The ABA, Mr. Ignacio Almada, the ATU, Mr. E. B. Brown, Casa de Proyecto Libertad, the Colorado DPS, the CVSA, the FJF, Greyhound, the LULAC, Mr. Evan Nacherlilla, the NCLR, the San Mateo County Transit District, and the Texas DPS expressed support for making all the FMCSRs applicable to the operators of small passenger-carrying CMVs. Greyhound stated:

Greyhound respectfully urges the Department of Transportation (DOT) to fully apply the Federal Motor Carrier Safety Regulations (FMCSRs) (except drug and alcohol testing and CDL requirements) to all interstate and international for-hire van service performed in the United States when such service extends beyond the commercial zones of cities or similar local boundaries and is performed by entities primarily engaged in providing surface transportation.

This compromise position provides safety regulation for those long haul van operators who are not now subject to meaningful regulation and whose safety record, in terms of fatalities, is far worse than the highly regulated intercity bus industry, which provides comparable service. At the same time, it exempts from federal regulation those short haul and incidental operators, such as vanpools, limousine operators, and rental car and hotel shuttles, whose operations may not be appropriate for federal safety regulation.

Substantial record evidence, including nationwide surveys submitted both in response to the ANPRM and again with these comments, demonstrates that long haul commercial vans are involved in a high level of fatal accidents, yet they are not subject to the federal safety regulations—driver qualifications, hours of service, and vehicle inspection and maintenance requirements—that are intended to prevent those accidents.

It is this type of evidence that led Congress to enact section 4008 of TEA–21 mandating application of the FMCSRs to commercial van operators by June 9, 1999 except to the extent that DOT through a rulemaking exempted some of those operators. That deadline is long passed and it is time for DOT to act expeditiously to protect the public by adopting a final rule applying the FMCSRs to long haul commercial vans.

Greyhound included in its comments information about recent accidents involving small passenger-carrying CMVs. Greyhound stated:

Greyhound conducted a nationwide clippings survey of all van accidents during the third quarter of 1998. Greyhound took the survey results, analyzed each news report, and eliminated all accidents that involved, or appeared to involve, all family, church, or other not-for-hire vans. What remained were 23 commercial van accidents involving 64 fatalities and over 100 injuries. On an annualized basis, this is 92 accidents, 256 fatalities and over 400 injuries. Greyhound's October 5, 1998 letter transmitting that survey to the docket is attached hereto as Attachment 1.

As part of this reply, we have done the same thing for the third quarter of 1999. The number of fatalities for 1999 is somewhat higher than for 1998. In the third quarter of 1999, there were 26 commercial van accidents involving 69 fatalities and approximately 150 injuries. On an annualized basis, that is 104 fatal accidents with 276 deaths and approximately 600 injuries. We attach hereto as Attachment 2, the third quarter, 1999 newspaper reports of fatal accidents that definitely or apparently involve commercial vans.

The ABA indicated that its members support making the FMCSRs applicable to the operators of small passenger-carrying CMVs. The ABA stated:

(T)he need to apply the FMCSRs to 9–15 passenger vans is more than a theoretical concern. ABA and its members have presented substantial evidence to the FHWA of the extensive scope of small passenger van operations throughout the United States. While it is true that neither ABA nor the FHWA has comprehensive data on the extent of compensated transportation services currently provided by operators of vans seating 9 to 15 passengers, ABA has discovered information indicating that this is a substantial and growing market, particularly but not exclusively in markets for predominantly Hispanic passengers. Moreover, this service is not merely local in scope, but includes interstate service throughout the United States, and foreign commerce service to and from Mexico.

In 1995, ABA member Greyhound Lines, Inc. provided to the FHWA and Congress information on the growth of van service emanating from Houston, Texas. That data showed literally dozens [of] operators performing van and motorcoach service from points in Mexico to points throughout the United States. Not any of that service was subject to the FMCSRs to the extent the vehicles carried fewer than 16 passengers.

The ABA indicated that it believes the accident data submitted by Greyhound should be sufficient in proving that there is a safety problem with operators of small passenger-carrying CMVs.

Several organizations and one State agency believe the FMCSA's rulemaking is necessary to improve the operational safety of vans used by motor carriers transporting migrant workers, immigrants, and people of Hispanic descent. Casa de Proyecto Libertad (or Liberty Project), an immigrant advocacy group in the Rio Grande Valley, stated:

It has come to our attention that many of these migrants are dying after entering the United States as victims of unregulated commercial passenger vans. These vans, or camionetas, operate on the Southwest border, traveling great distances between points in Mexico and the U.S. They are often operated over 12 hours a day by one driver and are packed full with migrants, vastly exceeding the 9 to 15 passenger limit. These already bad conditions are often exacerbated by worn tires and poorly working brakes. We at Proyecto Libertad work to better the futures of migrants and refugees, however it is of great concern to us that the safety of these same people is compromised because these vans are not required to meet federal safety standards. A majority of the deaths that result from this unregulated industry involve Hispanics; out of an estimated 250 casualties per year, 60 percent are Hispanic.

The regulations that the FHWA is presently exploring are an important first step, however, we also believe that there are further safety components that should be covered. The absence of regulation allows anyone to set up a business to transport paying passengers without concern for any margin of safety, no matter how small. Therefore, it is important to step up any regulation that FHWA considers with some simple but necessary requirements for commercial passenger vans including: length of driving time, basic vehicle safety standards and maintenance requirements, and stricter driver qualifications.

In order to improve the industry's safety record, FHWA must commit to taking the regulations to a higher level of safety. FHWA will, in effect, be stepping in to save lives of people unwittingly using unsafe commercial passenger vans, as well as those who come in contact with them on the country's roads.

The National Council of La Raza and the Farmworker Justice Fund, Inc. also submitted comments concerning the safety of Hispanic passengers. The FJF described itself as a litigation and advocacy organization that represents migrant and seasonal farmworkers around the nation. Its primary focus is on wages and working conditions, occupational health and safety, immigration status, and women's rights. The NCLR and the FJF stated:

Both NCLR and FJF support the proposed regulations for interstate commercial passenger vans designed for 9–15 passengers, but only as part of the overall applications of the FMCSRs to this group. The proposed exemption of for-hire passenger vehicles from basic safety regulations will result in the loss of hundreds of lives each year, most of them Latino migrant workers traveling from border states to the central U.S. states in commercial interstate passenger vans known as camionetas. The vast majority—80 percent by some estimates—of the victims who have died as a result of the use of these unregulated vehicles is Latino. Allowing these camionetas to continue to be in use without regulation is tantamount to dismissing the lives of their victims as insubstantial.

Camionetas typically are older, dilapidated vans. Border guards report that balding tires, worn brakes, lack of seatbelts and fire extinguishers are the norm for these vehicles. Instead of 15 passengers that these vehicles are designed to carry, camionetas are often overcrowded with 30 passengers or more. To save money, camioneta owners often assign only one driver for the long journey. Each of these factors poses significant safety risks.

The Texas DPS stated:

(We) can fully appreciate the dilemma that the revision of the definition of a commercial motor vehicle creates for the FHWA, as many small businesses would become subject to the regulations. There is no way to determine how many new motor carriers, drivers, and vehicles would be subject to the new requirements. While the new definition will create an inequitable situation for some of these carriers, we must not lose sight of what I believe was the primary inpetus behind the change in the definition—the ''camionetas'' operating between major cities in Texas and the other southern states to and from our borders with Mexico. We have been in discussion with the Texas Bus Association over the past three years concerning the operation of the camionetas in Texas. These vehicles and drivers often provide the same transportation services over the same routes as the large bus companies, with the benefit of not having to comply with the safety regulations. The drivers operate unregulated for longer hours than their bus counterparts in vans that endure an enormous amount of wear and tear on a daily basis. The passengers that subscribe to the service these carriers provide do so because of choice, convenience, and a greater sense of security with the driver and carrier. However, their decision to use these carriers should not be interpreted as a waiver of their rights to the same protection and safety assurances that they would receive by travelling on a major bus line.

While the camionetas may be the prime reason for the change in the definition of a commercial motor vehicle, (we) would suspect that there are other van services within the nation that inspire similar safety concerns. There are other van services that will be included in this definition and made subject to the FMCSR that should be exempted. Day care centers and hotel shuttle vans may be prime examples of these carriers. However, (we) cannot endorse exempting these carriers from the regulations since they operate wholly within a municipality's commercial zone and will have little direct exposure to the state agencies that normally enforce the FMCSR. There are many municipal police agencies that are also authorized to enforce the FMCSR that may have a legitimate need to regulate these carriers within their jurisdictions. (We) believe that their opinion on the issue should be considered.

Comments in Opposition to Making the FMCSRs Applicable to Operators of Small CMVs

Mr. Rick Farris and the Iowa Department of Transportation expressed opposition to making the FMCSRs applicable to operators of small passenger-carrying CMVs subject to the FMCSRs. The ACRA, ITLA, NADA, NFDA, and NLA opposed making the FMCSRs applicable to their respective members, rather than expressing total opposition to regulating operators of small passenger-carrying CMVs.

The ACRA stated:

ACRA advocates that the Agency postpone regulating small passenger-carrying motor vehicles until evidence is available that demonstrates these vehicles pose a safety risk. Congress has given FHWA the discretion to regulate these vehicles based upon FHWA's expertise in the area of CMVs. If the Agency does not have the information available to consider these smaller CMVs a safety risk, then FHWA should develop that information before deciding to regulate. In all cases of government action, there should be a firm factual foundation for the action—that foundation should not be developed after the promulgation of potentially burdensome regulations.

If FHWA decides to move forward with this rulemaking, ACRA urges that the Agency find that airport shuttle vans and buses with passenger capacities of 15 or less, such as those operated by car rental companies, fall outside the definition of ''commercial motor vehicles.'' Car rental shuttle services do not fall within the scope of Congress' intent because these shuttle services are not ''for compensation'' within the plain or economic meaning of that term. They merely provide a courtesy service for potential customers of a car rental agency. The fact that car rental shuttle services are operated by ''businesses'' (as referenced in the Agency's Regulatory Guidance for FMCSRs) is not, in and of itself, sufficient to extend the federal government's regulatory reach over this small subgroup of small passenger-carrying motor vehicles.

If FHWA ultimately ignores this argument and decides to cover these courtesy shuttles within the scope of this rulemaking, ACRA urges the Agency to restrict the scope of its regulations to the three areas proposed in the NPRM. Considering the limited factual foundation that FHWA has for classifying these smaller vehicles as CMVs, it is not appropriate to burden the owners of these vehicles with the full regulatory requirements of the FMCSRs. If FHWA is intent on regulating these smaller vehicles, then the limited burdens proposed in the NPRM would be far preferable to full FMCSR application.

The ITLA expressed concern about imposing the FMCSR's on the operators of small passenger-carrying CMVs given the apparent lack of data on the safety of such operators. The ITLA stated:

ITLA's position is that FHWA must extend the current six month extension if the rulemaking concerning the application of the limited FMCSRs is not complete at the time that the current six month exemption expires. It is ITLA's reading of FHWA's NPRM that FHWA proposes to only apply the three requirements listed in the NPRM to the operators of small passenger-carrying CMVs, and that the rule proposed in the NPRM would continue to provide an exception to the general application of all of the FMCSRs except for the three listed. ITLA is totally opposed to the application of any other FMCSRs to small passenger-carrying CMVs unless and until FHWA obtains safety data indicating that other FMCSRs should be applied to this class of vehicle.

While the ITLA is opposed to making the safety regulations applicable to its members operating small passenger-carrying CMVs, the association believes certain types of vanpool operations should be regulated if the agency regulates the operation of small CMVs. In its comments to the interim final rule the ITLA stated:

ITLA is very concerned with the FHWA's indicated position that it will not make the FMCSRs applicable to vanpools. FHWA has indicated that it does not intend to ''regulate commuter vanpools that are not operated in the furtherance of a commercial enterprise.'' FHWA limits its discussion of this issue to vans which are operated by individuals as part of a ''vanpooling'' arrangement. FHWA appears to dismiss, as irrelevant, the fact that members of the vanpool may pay a monthly fee to an individual to provide the vanpool service. This vanpool service could easily be provided in lieu of a commercial enterprise. The fact the individual providing the service is not a business seems to be irrelevant. The type of service being provided should be the controlling factor. In addition, FHWA totally ignores the fact that several companies provide vans to their employees to operate vanpools. In addition, ITLA must presume that FHWA intends to apply applicable FMCSRs to operators of vans which provide vanpool services as a commercial enterprise. ITLA urges the FHWA to closely reexamine this issue before making a final determination concerning the applicability of the FMCSRs to ''non-commercial'' vanpools.

The NFDA indicated that its members generally do not operate vehicles designed or used to transport 9 to 15 passengers. However, the organization believes that when such vehicles are operated in a funeral procession, they should be exempt from Federal safety regulations. The NFDA stated:

While most funeral homes provide limousine services to families, the vast majority of these vehicles are not designed or used to transport more than 8 passengers. However, there are members of NFDA that do provide funeral livery vehicles that can transport more than 8 passengers and which would be subject to the Interim Final Rule.

NFDA believes that an exemption is warranted for vehicles used in connection with a funeral service since they are typically operating in a funeral procession under a police escort and subject to special state and local laws * * *.

Given these precautions and the fact that funeral processions typically travel short distances and at low speeds under a police escort, an exemption from the Interim Final Rule is warranted for a commercial motor vehicle designed or used to transport more than 8 passengers that is used in connection with a funeral service or funeral procession. NFDA respectfully requests that commercial motor vehicles designed or used to transport more than 8 passengers (including the driver) for compensation be exempt from the Interim Final Rule when used in connection with a funeral service or funeral procession.

Comments Concerning the Definition of the Term ''For Compensation'' and Recommendations on Types of Carriage That Should Be Regulated

The preamble to the NPRM included a discussion of the term ''for compensation.'' The discussion referenced certain regulatory guidance the agency published in the **Federal Register** on April 4, 1997 (62 FR 16370). The agency indicated that the term ''for compensation'' was considered the same as ''for hire'' and discussed its interpretation of for-hire motor carriers. The NADA disagreed with the agency's interpretation of what constitutes a for-hire motor carrier. The NADA stated:

NADA strongly disagrees with this interpretation and the FHWA's reliance on it to justify the potential regulation of 12 or 15 passenger vans used by dealerships to shuttle customers at no cost. Regarding dealerships that operate courtesy shuttles in interstate commerce, NADA knows of none that charge riders a fee. Moreover, service customers who ride these shuttles are not charged more for vehicle repair or service work than customers who do not.

In its proposal, the FHWA seems to suggest that Congress did not intend for the FHWA to regulate van pools, schools or school bus contractors. If so, then it follows logically that Congress did not intend for free shuttle services to be regulated. Unlike free shuttle service riders, van poolers, school systems and community bus users ''compensate'' directly or indirectly for their transportation. From a policy standpoint, free shuttle services are akin to van pools in that they reduce traffic congestion and air pollution by eliminating the use of a greater number of vehicles with fewer occupants in each vehicle.

What Congress did intend to regulate was entities which are primarily or significantly in the business of for-hire people transportation. Certainly these would include bus, commercial van or taxi services operating vehicles such as 12 and 15 passenger vans or 11 passenger limousines in interstate commerce. In the interest of avoiding an overly expansive definition and in the interest of clarity, the FHWA should promulgate a final rule that defines for-hire transportation to include only directly compensated, fee-paid transportation. Of course, NADA recognizes that dealerships operating courtesy shuttle vans not for compensation are subject to the over 15 passenger vehicle set out in 49 USC 31132(1)(C).

The ABA also provided comments concerning the meaning of the term ''for compensation.'' The ABA believes the FMCSA should interpret the term in a way that limits the scope of the rulemaking to entities primarily engaged in the for-hire transportation of passengers. The ABA believes the scope of the rulemaking should be further limited to small passenger-carrying CMV operations outside of commercial zones, as defined in 49 CFR part 372. The ABA stated:

ABA continues to believe that the term ''for compensation'' be defined the same as the term ''for hire,'' and agrees with FHWA's assertion that the term ''for compensation'' is synonymous with ''for-hire.'' However, ABA proposes that the FHWA adopt the ''primarily engaged in'' test and the ''commercial zone'' exemption discussed above. This approach will allow the FHWA to retain its current definitions and policies, minimize the burden on these non-transportation companies and greatly reduce the populations of new entities for enforcement purposes.

The ABA indicated that it does not believe that hotel and rental car shuttles should be covered under the FMCSRs. Since theses operations are primarily non-transportation businesses, they should not be considered for-hire passenger carriers.

Comments Concerning the MCS–150

Mr. Evan Nacherlilla and Mr. Ignacio Almada believe the FMCSA should collect information concerning each employee's and driver's previous driving record, experience, and criminal record. These commenters also believe the agency should create a database available to the general public via the Internet that identifies all motor carriers operating small passenger-carrying CMVs. They argue that this will allow the public to make informed decisions whether to engage in business with certain motor carriers.

Comments Concerning Marking of CMVs

The ITLA and the NFDA opposed the proposal that operators of small passenger-carrying CMVs be required to mark their vehicles in accordance with 49 CFR 390.21. The ITLA stated:

Although the ITLA recognizes the limited applicability of FMCSRs that FHWA is proposing, the ITLA does question the necessity of imposing the marking requirements of 49 CFR 390.21 on limousines and other ''luxury-type passenger service'' vehicles. Under the provisions of 49 CFR 390.401, limousines and other ''luxury-type passenger service'' vehicles with a capacity of six or fewer passengers are exempt from the marking requirements of 49 CFR part 390, Subpart D. ITLA urges the FHWA to expand this exemption to vehicles providing similar services which carry 9 to 15 passengers including the driver. The nature of the service provided in such vehicles is luxury service, as acknowledged by FHWA in the existing regulations at 49 CFR 390.401. The imposition of the marking requirements on larger capacity limousines and other luxury-type passenger service'' vehicles would appear to serve no useful safety purpose, but would diminish or eliminate the ''luxury'' nature of the service provided by unnecessarily marking the vehicles in question.

The NFDA stated:

While this regulation does not impose undue regulatory burdens for most motor carriers operating CMVs, they would cause significant consumer dissatisfaction with funeral homes operating CMVs. It would offend many funeral consumers if limousines used by funeral homes were marked with ODOT numbers and the name and address of the funeral home. These markings would appear to many consumers as an undignified advertisement painted on a limousine that is being used in connection with a funeral service. For these reasons, NFDA would request exemption from the proposed regulation for all CMVs used by a funeral home in connection with a funeral service or funeral procession.

Comments Concerning the Proposal to Require an Accident Register

Mr. Evan Nacherlilla and Mr. Ignacio Almada believe the accident register for the operators of small passenger-carrying vehicles should include the ''legal conclusion to the accident and the individual dollar amount in damage to all vehicles involved.'' These commenters indicated that documenting this information would make it easier for any interested party to determine if the driver of the CMV was responsible for the accident, and to determine the severity of the accident. They also suggest that the accident register cover all accidents for the previous 60 months.

FMCSA Response to Comments

The FMCSA has carefully considered all of the comments received in response to the interim final rule and the NPRM. We have grouped the comments by subject for discussion.

Safety Performance Information Submitted by Commenters

The ABA, ATU, Casa de Proyecto Libertad, and Greyhound have presented compelling information detailing accidents and deaths occurring in small passenger vans in the United States. These submissions indicate that commercial van transportation is increasing across the country, particularly in markets serving the U.S.–Mexico border. The camionetas operations along the border were singled out in the comments as posing significant unregulated safety risks to passengers and the travelling public. The Texas DPS echoed this view and recommended they should be subject to the FMCSRs. Notwithstanding the emphasis on camionetas operations, the commenters raise questions about the safety of other long-haul, interstate van operators as well.

The information presented by the various commenters raises safety issues

the FMCSA must address. Our plan to address the issues begins with this final rule. When this rule becomes effective, all businesses operating vehicles designed or used to transport 9 to 15 passengers (including the driver) for compensation in interstate commerce will be required to complete a motor carrier identification report, mark their vehicles with a USDOT identification number, and maintain an accident register. The agency is taking this action to gather information about the operations and safety of motor carriers operating small passenger-carrying vehicles for compensation.

Elsewhere in today's **Federal Register**, the FMCSA published another rulemaking required by section 212 of the MCSIA. It addresses the safety oversight of camionetas operations and other van operations that might pose a serious safety risk and, consequently, focuses on many concerns raised by the commenters in this proceeding. For that reason, the FMCSA requests that those who have participated in this rulemaking assist the agency in implementing section 212 of the MCSIA. The accident information from news clippings paints a vivid, but indiscriminate, picture of safety problems in van transportation. The challenge for the FMCSA is to develop information that enables the agency to focus its regulations on the industry segment that poses serious safety risks. By this rulemaking, the FMCSA has narrowed its focus to for-hire motor carriers operating vehicles designed or used to transport 9 to 15 passengers in interstate commerce. The other rulemaking concerning section 212 of the MCSIA considers which segments of that group should be subject to the safety-related operational FMCSRs. The agency encourages all interested parties to respond to the notice of proposed rulemaking on this subject and welcomes information that helps us make that determination.

Response to Comments Concerning the Meaning of the Phrase ''For Compensation''

The FMCSA recognizes the concerns that the ABA, ACRA, Greyhound, NADA, and NFDA have about how the agency interprets the phrase ''for compensation.'' Although these commenters believe the phrase should, for the purpose of implementing section 4008 of the TEA–21, be interpreted to be applicable to only those entities that are directly compensated (*i.e.*, entities that are primarily engaged in the for-hire transportation of passengers), the FMCSA will continue to use the broader interpretation of the phrase. The agency stands by its previously stated position that the phrase ''for compensation'' is synonymous with ''for hire'' and its April 4, 1997 (62 FR 16370, 16407), interpretation of ''for-hire motor carrier.'' The interpretation states:

> The FHWA has determined that any *business* (emphasis added) entity that assesses a fee, monetary or otherwise, directly or indirectly for the transportation of passengers is operating as a for-hire carrier. Thus, the transportation for compensation in interstate commerce of passengers by motor vehicles (except in six-passenger taxicabs operating on fixed routes) in the following operations would typically be subject to all parts of the FMCSRs, including part 387: whitewater river rafters; hotel/motel shuttle transporters; rental car shuttle services, etc. These are examples of for-hire carriage because some fee is charged, usually indirectly in a total package charge or other assessment for transportation performed.

The reference to six-passenger taxicabs operating on fixed routes was included in the guidance due to a CMV definition set forth in the ICCTA. The ICCTA amended the statutory definition of a CMV, adding ''designed or used to transport passengers for compensation, but exclud[es] vehicles providing taxicab service and having a capacity of not more than 6 passengers and not operated on a regular route or between specified places.'' The TEA–21 definition removed this clause from the definition of CMV.

The interpretation simply lays out the agency's view of its statutory authority, and the current applicability of the safety regulations to certain for-hire motor carriers.

Response to Comments About Transportation of Migrant Workers

The FMCSA recognizes that some commenters believe that migrant workers face disproportionately high fatality rates in small passenger-carrying CMVs because the FMCSRs do not apply. Although the FMCSRs do not apply to small vans at this time, the FMCSA has in place safety regulations applicable to motor carriers that transport migrant workers more than 75 miles in interstate or foreign commerce (49 CFR part 398). These regulations apply to any person, with certain limited exceptions, who transports in interstate or foreign commerce at any one time three or more migrant workers to or from their employment by any motor vehicle other than a passenger automobile or station wagon. Overall, the rules address the safety concerns expressed by commenters. For example, § 398.6 prohibits drivers from operating a vehicle for more than 10 hours in any 24-hour period, unless the driver is given 8 hours rest immediately following the 10 hours driving time. Drivers must meet the physical qualification standards in § 398.3 to qualify as a driver of migrant workers. Equipment standards are prescribed in § 398.4 to ensure that the carrier's motor vehicles are safe. Moreover, carriers are required to have their vehicles systematically inspected (§ 398.7). As these regulations prescribe broad safety standards for motor carriers of migrant workers, the FMCSA does not see a basis for additional regulation in this specific segment of the industry.

Response to Comments Concerning Information on the Form MCS–150

The FMCSA has considered Mr. Evan Nacherlilla's and Mr. Ignacio Almada's comments concerning the collection of data on the Form MCS–150 about individual driving records, experience, and criminal records. Motor carriers are already required to consider driving records and information from previous employers as part of the process for hiring drivers. The FMCSA believes that this responsibility should remain with the employer and sees no public benefit to having the agency collect this information. With regard to Mr. Evan Nacherlilla's and Mr. Ignacio Almada's comments about the creation of a database that identifies all motor carriers operating small passenger-carrying CMVs, the FMCSA has already developed databases of all interstate motor carriers that have complied with the agency's requirement to complete the motor carrier identification report (see 49 CFR 390.19), and for-hire motor carriers that must obtain operating authority (see 49 CFR part 365). The public may request safety profiles of interstate motor carriers by calling 1–800–832–5660. The public may also obtain information about motor carriers via the Internet by visiting the agency's website at *http://www.fmcsa.dot.gov*.

Response to Comments Concerning Marking of CMVs

The FMCSA continues to believe that small passenger-carrying CMVs should be marked to help enforcement officials and the general public identify these vehicles. However, after considering the comments received in response to the NPRM, the agency has determined that marking these vehicles with USDOT identification numbers only is sufficient at this time. The agency is not requiring that the name of the carrier, and the principal place of business be marked on these CMVs. The types of passenger-carrying operations being conducted by many of these businesses (*e.g.,* vehicles in funeral processions) is such that it would be distasteful to clients and

customers to have the vehicles marked in the same manner as larger CMVs. Clients and customers of limousine services and other luxury-type passenger service would most likely prefer that the vehicles be discretely marked. A requirement that these vehicles display the name of the motor carrier and principal place of business with markings that are readily legible, during daylight hours, from a distance of 50 feet while the vehicle is stationary would be anything but discrete. Marking the vehicles with the USDOT identification number only, would provide a unique identifier linking the vehicle to the motor carrier, without being a visual annoyance to clients and customers. The identification number must be visible from a distance of 50 feet from the CMV, but this requirement should be much less offensive to customers than displaying the name and principal place of business for the motor carrier.

The FMCSA believes that, given the relatively small size of vehicles designed or used to transport 9 to 15 passengers (including the driver) for compensation when compared to other CMVs, motorists should be able to quickly locate the USDOT identification numbers displayed on the sides of the vehicles. Further, motorists should be able to see the license plate(s) on these small CMVs more easily than those on larger vehicles. For urgent matters (such as accidents or allegations of dangerous driver behavior) that necessitate immediate action by State or local law enforcement officials, the license plates will enable those officials to trace the vehicle back to the registered owner (*i.e.,* the motor carrier or leasing company) and the display of the company name and principal place of business is not critical. For other matters, such as individuals who wish to submit complaints about unsafe motor carriers (*e.g.,* motorists who have only the USDOT identification number, clients or customers who know only the name of the business, or motor carrier employees reporting information about their employers), the FMCSA will have sufficient information to locate these carriers and take appropriate action. Accordingly, the FMCSA will only require that small passenger-carrying CMVs be marked with the USDOT identification number.

Response to Comments About the Accident Register

The FMCSA does not believe it is necessary to require that the accident register include more information than is currently required by 49 CFR 390.15. There is no discernible benefit to Mr. Evan Nacherlilla's and Mr. Ignacio Almada's suggestion that the agency require motor carriers to include in their accident registers information about findings of guilt or innocence for each accident. The agency also sees little benefit to requiring that information be retained by the motor carrier for 60 months. The commenters have not provided any information to suggest that the current requirements are insufficient.

The FMCSA is concerned about the total number of accidents, as defined in 49 CFR 390.5, that a motor carrier has experienced for the previous 12 months, when an assessment of the motor carrier's safety management controls must be made. The agency calculates motor carriers' accident rates (the number of recordable accidents per million miles of CMV travel) as part of the process for determining their safety rating. Accidents are a factor in that process when a motor carrier incurs two or more recordable accidents within the 12 months prior to a compliance review. The agency considers ''preventability'' when a motor carrier contests a rating by presenting compelling evidence that the recordable rate is not a fair means of evaluating its accident factor. The agency uses the following standard in making a determination of preventability: ''If a driver, who exercises normal judgment and foresight could have foreseen the possibility of the accident that in fact occurred, and avoided it by taking steps within his/her control which would not have risked causing another kind of mishap, the accident was preventable.'' This standard is presented in appendix B to part 385, Explanation of Safety Rating Process.

The commenters have not provided any information to support the implicit assertion that the current accident information used as a factor in assessing a motor carrier's safety fitness is inadequate. Irrespective of whether the driver receives a ticket for violating State or local traffic laws, or is convicted of a more serious offense, the FMCSA continues to believe that all recordable accidents should be considered when determining a motor carrier's safety fitness. The FMCSA is able to obtain all the information it needs concerning accidents involving a motor carrier subject to 49 CFR 390.15, either from other records maintained by the motor carrier or from State or local enforcement agencies that responded to the accident(s) in question. Therefore, the FMCSA has in place a reliable means of gathering information about accidents involving fatalities, injuries requiring medical treatment away from the scene of the accident, or disabling damage to any of the vehicles involved in the incident.

With regard to the suggestion that the accident register include the dollar amount of damages in each accident, the FMCSA does not believe such information is a reliable means of assessing the severity of accidents. For example, a CMV collision involving the total loss of an expensive brand new import car would be listed as a more severe accident than one involving the total loss of 10-year-old import car of the same make and model. The fatality, injury, and disabling damage criteria provide a more effective means of distinguishing between accidents involving only minor injuries and/or property damage, and those that are more severe.

Discussion of the Final Rule

The FMCSA is making final the amendments to the definition of ''commercial motor vehicle'' in § 390.5 that were adopted on an interim final basis on September 3, 1999 (64 FR at 48516–48517). All of the amendments are based on statute. The FMCSA is also adopting a revised version of § 390.3(f)(6) to require that operators of CMVs designed or used to transport 9 to 15 passengers for compensation complete a motor carrier identification report (49 CFR 390.19), comply with certain provisions of the CMV marking regulation (49 CFR 390.21, except § 390.21(b)(1)), and maintain an accident register (49 CFR 390.15). These actions will enable us to monitor the operational safety of all motor carriers operating small passenger vehicles for compensation. In addition, the three requirements will help the agency compile information on the number of motor carriers operating small passenger-carrying vehicles for compensation, the locations of their principal places of businesses, the number of vehicles operated, and the number of drivers employed. Through marking of the vehicles with USDOT identification numbers, State agencies will be able to identify small passenger-carrying vehicles and collect accident data for submission to the FMCSA through the agency's SAFETYNET database. The requirement that motor carriers operating small passenger-carrying CMVs maintain accident information will enable the agency to conduct special studies concerning the safety performance of these carriers.

Motor Carrier Identification Report

Section 390.19 of the FMCSRs requires motor carriers to file Form MCS–150, Motor Carrier Identification

Report, before beginning operations in interstate commerce, and to file an update of the report every 24 months. The information from the Form MCS–150 is used to create a file in the Motor Carrier Management Information System (MCMIS), a database containing safety information about interstate motor carriers (e.g., compliance review results, roadside inspection results, CMV accidents, etc.).

The FMCSA is requiring that operators of small passenger-carrying CMVs file Form MCS–150 to enable the agency to determine how many motor carriers are affected by the TEA–21 revision to the CMV definition, the number of drivers employed and vehicles operated by these carriers, and the principal place of business for each of these entities. Each motor carrier will be assigned a USDOT census or identification number which, when marked on each CMV operated by the motor carrier, will help enforcement officials and the general public identify these businesses.

Vehicle Marking

Section 390.21 requires that motor carriers mark their CMVs with the name or trade name of the business, the city or community and State in which the motor carrier maintains its principal place of business, and its motor carrier identification number. The FMCSA is requiring the operators of small passenger-carrying vehicles to comply with all the provisions of the marking rule, except § 390.21(b)(1) concerning the display of the name or trade name of the motor carrier. This will help to ensure that enforcement officials and the public can identify motor carriers' vehicles and that accidents (as defined in 49 CFR 390.5) can be recorded by the States and entered into the FMCSA's SAFETYNET database. The FMCSA will use the information to study the number and locations of accidents, and the motor carriers involved, to determine if there are patterns or trends concerning the safety performance of these carriers.

Accident Register

Section 390.15 requires that motor carriers make all records and information pertaining to an accident available to the FMCSA upon request. Motor carriers must give the agency all reasonable assistance in the investigation of any accident. Motor carriers also must maintain at the principal place of business, for a period of one year after an accident occurs, an accident register with the following information:

(1) Date of the accident;

(2) City or town in which or most near where the accident occurred, and the State in which the accident occurred;

(3) Driver's name;

(4) Number of injuries;

(5) Number of fatalities; and

(6) Whether hazardous materials, other than fuel spilled from the fuel tanks of the motor vehicles involved in the accident, were released.

Copies of all accident reports required by State or other government entities or insurers also must be maintained by the motor carriers.

The FMCSA is requiring that operators of CMVs designed or used to transport 9 to 15 passengers for compensation be required to comply with § 390.15 to assist the agency in conducting investigations and, if necessary, special studies about the safety performance of particular motor carriers or segments of the industry. For example, if one of a motor carrier's small passenger-carrying vehicles is involved in a major accident or a series of accidents, the FMCSA could review the records required by § 390.15 as part of the process of determining whether there are deficiencies with the carrier's safety management controls.

Explanation of the Term ''For Compensation''

The TEA–21 definition of a passenger CMV includes the phrase ''for compensation'' in 49 U.S.C. 31132(1)(B). However, the TEA–21 did not include a definition of the phrase. As stated above, the FMCSA considers the term to be synonymous with ''for hire.'' The FMCSA intends that this rulemaking be applicable to all interstate for-hire motor carriers of passengers operating CMVs designed or used to transport 9 to 15 people. Although some commenters to the interim final rule and NPRM suggested that a distinction be made between businesses that are primarily engaged in the for-hire transportation of passengers and those that are primarily engaged in a non-transportation related enterprise, the agency does not believe it is appropriate to exempt a for-hire motor carrier from the requirements being proposed on the basis of how the motor carrier is paid for its services.

Rulemaking Analysis and Notices

Executive Order 12866 (Regulatory Planning and Review) and DOT Regulatory Policies and Procedures

The FMCSA has determined that this action is a significant regulatory action within the meaning of Executive Order 12866 and significant within the meaning of Department of Transportation regulatory policies and procedures because of the substantial public interest concerning the possible extension of the applicability of the FMCSRs to a larger population of motor carrier operations. This rule requires that operators of vehicles designed or used to carry between 9 and 15 passengers (including the driver) for compensation, in interstate commerce, file a motor carrier identification report, mark their CMVs with a USDOT identification number, and maintain an accident register.

The FMCSA believes the costs of complying with the requirements to submit a motor carrier identification report and to maintain an accident register are negligible. These requirements impose only information collection burdens (*i.e.,* completion of forms, recordkeeping, etc.) and are discussed in greater detail below in the ''Paperwork Reduction Act'' section of this notice.

The FMCSA estimates that the cost of marking CMVs will be between $11 and $27 per vehicle depending on the number of vehicles the motor carrier operates. Although the actual cost to the industry should be less than that originally estimated in the agency's NPRM—the final rule requires that less information be displayed than was originally proposed—the FMCSA is using the same estimate range to avoid underestimating the burden on the industry. These cost estimates are based upon the FMCSA's regulatory evaluation and regulatory flexibility analysis prepared for the June 2, 2000 (65 FR 35287), final rule concerning CMV marking requirements. The complete regulatory evaluation and regulatory flexibility analysis are included in FMCSA Docket No. FMCSA–98–3947.

Since motor carriers operating CMVs designed or used to transport 9 to 15 passengers currently are not required to complete Form MCS–150, the FMCSA does not have sufficient data to estimate the total number of CMVs that would need to be marked in accordance with § 390.21. However, one of the commenters responding to the August 5, 1998, ANPRM (63 FR 41766) provided information that may be useful in estimating the population of vehicles that would need to be marked. The International Taxicab and Livery Association (ITLA) stated:

> According to information available to ITLA, there are approximately 50,000 limousines in use that would be affected by the definitional change. It should be noted that there are over 9000 limousine operators nationwide (also operating premium sedan services), and that the median fleet size is less than 5. In addition, the average annual

miles operated by limousines is approximately 23,000 miles.

ITLA estimates that there are approximately 74,000 vans nationwide—the breakdown between ''mini-vans'' and those affected by the proposed definition is not available. Van fleets average less than 10 vans, with an approximate annual mileage of 40,000 per vehicle, and an average trip length of less than 8 miles lasting significantly less than 1 hour.

In September of 1998, the American Business Information (a mailing list sales company) released a sales catalog that reports the following information:

SIC code	Type of service	# of U.S. companies
4111–01 ...	Airport Transportation.	4,752
4119–01 ...	Handicapped Transportation.	1,302
4119–03 ...	Limousine Transportation.	9,482
4121–01	Taxicab Transportation.	7,348
Total	.....	22,884

The ITLA indicated that, if the agency decides to make the FMCSRs applicable to the operation of small passenger-carrying vehicles, approximately 14,000 companies, 125,000 vehicles, and 165,000 drivers would be covered. If there are 125,000 vehicles designed or used to transport 9 to 15 passengers for compensation in interstate commerce, the costs to the industry for marking CMVs could be between $1,375,000 and $3,375,000. The costs are one-time expenses and would not be recurring. Generally, the marking would last the normal life of the vehicle.

At this time, the FMCSA is not able to specifically quantify the safety benefits resulting from requiring CMVs to be marked. The requirement is necessary because it would be used to monitor the safety performance of these motor carriers. The safety performance data ultimately would be used to determine whether there are safety problems with operators of small passenger-carrying CMVs, and whether other FMCSRs should be made applicable to them.

The FMCSA has considered other rulemaking options, such as not imposing any regulatory burdens on these motor carriers, excluding the marking requirements from this final rule, or imposing more stringent requirements. The agency believes the option chosen will be most effective at helping to achieve its objective to monitor the safety performance of these passenger carriers. Based upon the information above, the agency anticipates that the economic impact associated with this rulemaking action is minimal and a full regulatory evaluation is not necessary.

Regulatory Flexibility Act

In compliance with the Regulatory Flexibility Act (5 U.S.C. 601–612), the FMCSA has considered the effects of this regulatory action on small entities and determined that this rule will affect a substantial number of small entities, but will not have a significant impact on them. If the ITLA's estimate of 14,000 interstate motor carriers operating CMVs designed or used to transport 9 to 15 passengers is accurate, and most or all of these businesses are classified as small businesses by the Small Business Administration (SBA), the rule could affect up to 14,000 small entities.

Generally, the costs per vehicle for small companies to mark their CMVs will be greater than those for large companies. If a motor carrier has between 1 to 6 vehicles, the total cost per vehicle for marking is estimated at $27. The motor carrier's total cost would therefore be between $27 and $156. For a motor carrier operating 7 to 20 CMVs, the total cost per vehicle marking would be $21. The total cost for the motor carrier's fleet would be between $147 and $420. For a fleet of 21 to 99 vehicles, the total cost per vehicle marking would decrease to $16. The total cost for the motor carrier's fleet would be between $336 and $1,584. And, for a fleet of 100 to 999 vehicles the cost per vehicle marking would decrease to $11. The total fleet cost would be between $1,100 and $10,989.

For purposes of this rulemaking analysis, given the lack of any other relevant data on the subject, the FMCSA will use the ITLA's estimate for the number of businesses, vehicles, and drivers for these small passenger-carrying CMVs. The FMCSA's data concerning carriers that have operating authority can only be used to identify 1,648 interstate motor carriers operating vehicles designed or used to transport between 9 to 15 passengers. The agency believes there may be many more carriers and that the ITLA's estimate appears to be a reasonable number.

Based on its analysis summarized above, the FMCSA believes that this rulemaking could affect, but not have a significant impact on, a substantial number of small entities. For example, if a small entity operated between 7 and 20 CMVs, the total cost per vehicle marking would be $21. The total cost for the motor carrier's fleet would be between $147 and $420. The FMCSA does not consider this total fleet cost for marking the CMVs to be a significant impact on a business operating 20 vehicles, but a normal operating cost for doing business. The anticipated benefits (*i.e.*, enabling the FMCSA, State agencies, and others to identify small passenger-carrying vehicles involved in accidents and, in turn, determine whether additional regulatory requirements are necessary) outweigh the costs associated with this rule. Accordingly, the FMCSA has considered the economic impacts of the requirements on small entities and certifies that this rule would not have a significant economic impact on a substantial number of small entities.

Executive Order 12372 (Intergovernmental Review)

Catalog of Federal Domestic Assistance Program Number 20.217, Motor Carrier Safety. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities do not apply to this program.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct, sponsor, or require through regulations. The FMCSA has determined that this proposal contains new collection of information requirements for the purposes of the PRA. The FMCSA is requiring that motor carriers operating CMVs designed or used to transport 9 to 15 passengers meet the vehicle marking requirements at 49 CFR 390.21 (except § 390.21(b)(1)). The FMCSA believes it is important that small passenger-carrying CMVs be marked with USDOT numbers so that the public has an effective means to identify motor carriers operating in an unsafe manner. Such markings will also assist Federal and State officials in accident investigations.

The information collection requirements contained on Form MCS–150 have been approved by the OMB under the provisions of the PRA and assigned the control number of 2126–0013 which expires on October 31, 2002. The FMCSA estimates it takes approximately 20 minutes for interstate motor carriers to complete the Form MCS–150 the first time it is filed. The agency estimates that as a result of this rulemaking, 14,000 interstate motor carriers, currently not subject to the FMCSA's safety regulations, would have to complete the Form MCS–150. Motor carriers are required to complete the form before beginning operations in interstate commerce. Motor carriers

must also update the information submitted to the agency every 24 months. However, the agency estimates the update would take considerably less time because most of the information is likely to be the same and motor carriers would already have had the experience of completing the form at least once before the update. The agency estimates the update would take 10 minutes. Therefore, the FMCSA estimates an additional burden of 4,667 hours ((20 minutes per motor carrier × 14,000 motor carriers) / 60 minutes per hour) to OMB 2126–0013 for the initial filing of the Form MCS–150. The burden hours for OMB 2126–0013 would be further increased by 2,333 hours ((10 minutes per motor carrier × 14,000 motor carriers) / 60 minutes per hour) because of the biennial update. This final rule contains a requirement that businesses currently not subject to 49 CFR 390.19 file, and periodically update the Form MCS–150.

The information collection requirements for the accident register have been approved by the OMB under the provisions of the PRA and assigned the control number of 2126–0009 which expires on August 31, 2002. The FMCSA estimates it takes approximately 18 minutes for interstate motor carriers to collect and record the seven elements of information on the accident register. However, since the FMCSA does not have sufficient information to estimate the number of accidents operators of small passenger-carrying CMVs have each year, the agency is unable to estimate the total time burden. If each of the estimated 14,000 interstate motor carriers operating small passenger-carrying vehicles has one accident per year, an additional burden of 4,200 hours per year ((18 minutes per motor carrier × 14,000 motor carriers)/60 minutes per hour) would be added to OMB No. 2126–0009. This final rule requires businesses currently not subject to 49 CFR 390.15 to maintain an accident register.

The FMCSA submitted both of these revised information collections, as required, to OMB for review and approval at the time the September 3, 1999, NPRM was published. Interested parties were invited to send comments regarding these information collection requirements. There were no substantive comments received. Therefore, the FMCSA is requesting that the revised information collections be approved at this time and is submitting this request to OMB.

National Environmental Policy Act

The agency has analyzed this rulemaking for the purpose of the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*) and has determined that this action does not have any effect on the quality of the environment.

Unfunded Mandates Reform Act of 1995

This rule does not impose an unfunded Federal mandate, as defined by the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532 *et seq.*), that will result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year.

Executive Order 12988 (Civil Justice Reform)

This action meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Executive Order 13045 (Protection of Children)

The FMCSA has analyzed this action under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This rule is not an economically significant rule and does not concern an environmental risk to health or safety that may disproportionately affect children.

Executive Order 12630 (Taking of Private Property)

This rule will not effect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Executive Order 13132 (Federalism Assessment)

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 13132 dated August 4, 1999, and it has been determined that this rulemaking does not have a substantial direct effect or sufficient federalism implications on States that would limit the policymaking discretion of the States. Nothing in this document directly preempts any State law or regulation. This final rule does not impose additional costs or burdens on the States.

Regulation Identification Number

A regulatory identification number (RIN) is assigned to each regulatory action listed in the Unified Agenda of Federal Regulations. The Regulatory Information Service Center publishes the Unified Agenda in April and October of each year. The RINs contained in the heading of this document can be used to cross reference this action with the Unified Agenda.

List of Subjects in 49 CFR Part 390

Highway safety, Motor carriers, Motor vehicle identification and marking, Reporting and recordkeeping requirements.

Issued on: January 4, 2001.

Clyde J. Hart, Jr.,

Acting Deputy Administrator.

Accordingly, part 390 of Title 49 of the Code of Federal Regulations is amended as follows:

PART 390—[AMENDED]

1. Revise the authority citation for part 390 to read as follows:

Authority: 49 U.S.C. 13301, 13902, 31132, 31133, 31136, 31502, and 31504; sec. 204, Pub. L. 104–88, 109 Stat. 803, 941 (49 U.S.C. 701 note); and 49 CFR 1.73.

2. Amend § 390.3 to revise paragraph (f)(6) to read as follows:

§ 390.3 General applicability.

* * * * *

(f) *Exceptions.* * * *

(6) The operation of commercial motor vehicles designed or used to transport between 9 to 15 passengers (including the driver). However, motor carriers operating these vehicles for compensation are required to comply with 49 CFR 385.21, Motor carrier identification report, 49 CFR 390.15, Assistance in investigations and special studies, and 49 CFR 390.21, Marking of commercial motor vehicles (except § 390.21(b)(1)).

3. Amend § 390.5 to revise the definition of ''Commercial motor vehicle'' to read as follows:

§ 390.5 Definitions.

* * * * *

Commercial motor vehicle means any self-propelled or towed motor vehicle used on a highway in interstate commerce to transport passengers or property when the vehicle—

(1) Has a gross vehicle weight rating or gross combination weight rating, or gross vehicle weight or gross combination weight, of 4,536 kg (10,001 pounds) or more, whichever is greater; or

(2) Is designed or used to transport more than 8 passengers (including the driver) for compensation; or

(3) Is designed or used to transport more than 15 passengers, including the driver, and is not used to transport passengers for compensation; or

(4) Is used in transporting material found by the Secretary of Transportation to be hazardous under 49 U.S.C. 5103 and transported in a quantity requiring placarding under regulations prescribed by the Secretary under 49 CFR, subtitle B, chapter I, subchapter C.

[FR Doc. 01–765 Filed 1–10–01; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

49 CFR Parts 385, 390, and 398

[Docket No. FMCSA–2000–7017]

RIN 2126–AA52

Safety Requirements for Operators of Small Passenger-Carrying Commercial Motor Vehicles Used In Interstate Commerce

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of proposed rulemaking (NPRM); request for comments.

SUMMARY: The FMCSA is proposing to amend the Federal Motor Carrier Safety Regulations (FMCSRs) to require that motor carriers operating commercial motor vehicles (CMVs), designed or used to transport between 9 and 15 passengers (including the driver), in interstate commerce comply with the safety regulations when they are directly compensated for such services, and the transportation of any passenger covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers). Motor carriers, drivers, and the vehicles operated by them would be subject to the same safety requirements imposed upon motorcoach operations, with the exception of the commercial driver's license, controlled substances and alcohol testing regulations. The agency is proposing that any requirements implemented be made applicable to these motor carriers 90 days after the effective date of the final rule. This action is in response to section 212 of the Motor Carrier Safety Improvement Act of 1999 (MCSIA).

DATES: Comments must be received on or before April 11, 2001.

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 should include the docket number that appears in the heading of this document. 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: Mr. Larry W. Minor, Office of Bus and Truck Standards and Operations, (202) 366–1790, Federal Motor Carrier Safety Administration, 400 Seventh Street, SW., Washington, D.C. 20590–0001; or Mr. Michael Falk, Office of the Chief Counsel, HCC–20, (202) 366–1384, Federal Highway Administration, 400 Seventh Street, SW., Washington, D.C. 20590–0001. 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 web page at: *http://www.access.gpo.gov/nara.*

Background

Congressional Mandate to Regulate Small Passenger-Carrying CMVs

On December 9, 1999, the President signed the Motor Carrier Safety Improvement Act of 1999 (Pub. L. 106–159, 113 Stat. 1748). Section 212 of the MCSIA requires that the FMCSA make its safety regulations applicable to: (1) Commercial vans referred to as ''camionetas,'' and (2) those commercial vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks. The rulemaking to implement section 212 must be completed by December 9, 2000.

Prior to the enactment of the MCSIA, section 4008(a)(2) of the Transportation Equity Act for the 21st Century (TEA–21) (Pub. L. 105–178, 112 Stat. 107, June 9, 1998) amended the passenger-vehicle component of the CMV definition in 49 U.S.C. 31132(1). Commercial motor vehicle is now defined statutorily to mean a self-propelled or towed vehicle used on the highways in interstate commerce to transport passengers or property, if the vehicle—

(A) Has a gross vehicle weight rating or gross vehicle weight of at least 10,001 pounds, whichever is greater;

(B) Is designed or used to transport more than 8 passengers (including the driver) for compensation;

(C) Is designed or used to transport more than 15 passengers, including the driver, and is not used to transport passengers for compensation; or

(D) Is used in transporting material found by the Secretary of Transportation to be hazardous under section 5103 of this title and transported in a quantity requiring placarding under regulations prescribed by the Secretary under section 5103.

Under section 4008(b) of the TEA–21, operators of the CMVs defined by section 31132(1)(B) would automatically become subject to the FMCSRs one year after the date of enactment of the TEA–21, if they were not already covered, ''except to the extent that the Secretary (of Transportation) determines, through a rulemaking, that it is appropriate to exempt such operators of commercial motor vehicles from the application of those regulations.'' Section 4008(b) of the TEA–21 is a mandate either to impose the FMCSRs on previously unregulated smaller capacity passenger vehicles, or to exempt through notice and comment rulemaking some or all of the operators of such vehicles.

On September 3, 1999, the Federal Highway Administration (FHWA) published an interim final rule to adopt the new statutory definition of a CMV (64 FR 48510).[1] The agency revised its regulatory definition of CMV to be consistent with the statute, but exempted the operation of these small passenger-carrying vehicles from all of the FMCSRs for six months to allow time for the completion of a separate rulemaking in which the agency proposed requiring operators of such vehicles to file a motor carrier identification report, mark their CMVs with a USDOT identification number and certain other information, and maintain an accident register. This notice of proposed rulemaking was also

[1] The MCSIA established the FMCSA in the Department of Transportation. On January 4, 2000, the Office of the Secretary published a final rule rescinding the authority previously delegated to the former Office of Motor Carrier Safety (OMCS) (65 FR 220). This authority is now delegated to the FMCSA. Rulemaking, enforcement, and other activities of the Office of Motor Carrier Safety while part of the Federal Highway Administration (FHWA), and while operating independently of the FHWA, will be continued by the FMCSA.

published on September 3, 1999, at 64 FR 48518.

Elsewhere in today's **Federal Register**, the FMCSA published a final rule that amends § 390.5 by adopting the statutory definition of ''commercial motor vehicle'' published in the interim final rule on September 3, 1999. The agency's final rule also revised § 390.3(f)(6) to require that all operators of CMVs designed or used to transport between 9 and 15 passengers for compensation complete a motor carrier identification report (Form MCS–150) (49 CFR 390.19), comply with certain provisions of the CMV marking regulation (49 CFR 390.21), and maintain an accident register (49 CFR 390.15). These actions will enable the agency to monitor the operational safety of *all* motor carriers operating small passenger vehicles for compensation. In addition, the three requirements will help the agency compile information on the number of motor carriers operating small passenger-carrying vehicles for compensation, the location of their principal place of business, the number of vehicles operated, and the number of drivers employed.

With the enactment of the MCSIA, the agency is now required to make the safety-related operational FMCSRs (*e.g.,* driver qualifications, hours of service, inspection, repair and maintenance, etc.) applicable to certain operations of small passenger-carrying vehicles designed or used to transport between 9 and 15 passengers (including the driver) for compensation in interstate commerce. Namely, the small passenger-carrying CMV operations that must be regulated under section 212 of the MCSIA include what the Congress referred to as ''camionetas'' and those operations outside of commercial zones that have been determined to pose serious safety risks.

In this NPRM, the FMCSA is proposing to make the FMCSRs applicable to all motor carriers operating CMVs, designed or used to transport between 9 and 15 passengers (including the driver), in interstate commerce for ''direct compensation'' when the transportation covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers). This preliminary decision is based on: (1) The FMCSA's understanding of the Congress' and the commercial passenger carrier industry's usage of the term ''camioneta,'' (2) the agency's analysis of comments submitted in response to the FHWA's August 5, 1998 (63 FR 41766) advance notice of proposed rulemaking concerning the definition of CMV, (3) the agency's analysis of comments submitted in response to the September 3, 1999, interim final rule and notice of proposed rulemaking, and (4) an analysis of accident data concerning large vans. The agency believes that this approach would be more effective than other alternatives for responding to congressional and public safety concerns about what is commonly referred to as ''long-haul'' for-hire van operations throughout the United States, including vans operated for compensation by foreign-based motor carriers into and out of the United States.

The FMCSA considered several alternatives or options to implement section 212 of the MCSIA. The other alternatives included making the safety-related operational FMCSRs applicable to: (1) All motor carriers operating small passenger-carrying CMVs in interstate commerce for compensation (direct and indirect); (2) all motor carriers operating small passenger-carrying CMVs in interstate commerce that are *directly* compensated, irrespective of the distance traveled; and (3) only those motor carriers operating small passenger-carrying CMVs across the U.S.-Mexico border for compensation. The FMCSA believes the proposed alternative would avoid making the FMCSRs applicable to interstate for-hire van operations that are local in nature and do not appear to pose the same level of safety risks to their customers and the traveling public.

Passenger-Carrying Operations Covered by this Rulemaking

For-Hire Transportation—Direct versus Indirect Compensation

Although the Congress did not define ''for compensation,'' the FMCSA believes this rulemaking should focus first and foremost on motor carriers of passengers that offer their services to the general public in exchange for compensation. Generally, the primary business of these companies is providing interstate passenger transportation services. Although the FMCSA has applied identification marking and accident recording requirements on all interstate motor carriers transporting passengers for compensation, the agency does not believe the Congress intended to impose safety-related operational regulations on business entities providing interstate passenger transportation services that are incidental to their primary, non-transportation related business. While both types of operations are conducted for compensation, the FMCSA believes that it is important to distinguish between businesses with a primary objective of providing transportation, and others. The former group is directly compensated for their transportation services, while the latter is compensated indirectly in a total package charge or some other assessment or concession is given for the transportation performed.

In the comments submitted in response to the September 3, 1999, interim final rule and the notice of proposed rulemaking published on the same day, the American Bus Association (ABA), the American Car Rental Association, Greyhound, the National Automobile Dealers Association, and the National Funeral Directors Association expressed concerns about how the agency should interpret the phrase ''for compensation.'' These commenters believe the phrase should, for the purpose of implementing section 4008 of the TEA–21, be interpreted to be applicable to only those entities that are directly compensated (i.e., entities that are primarily engaged in the for-hire transportation of passengers). This issue is also discussed in the preamble of the final rule concerning requirements for operators of small passenger-carrying CMVs, published elsewhere in today's **Federal Register**. Interested parties may view the comments by reading the submissions to FMCSA Docket Nos. FMCSA–97–2858 and FMCSA–99–5710.

The FMCSA agrees with commenters to the previous rulemaking notices in their belief that only small passenger-carrying CMV operators that are directly compensated for their services should be required to comply with safety-related operational rules. These are the small passenger-carrying CMV operations that commenters identified as having significant deficiencies in their safety management controls for their drivers and vehicles. In implementing section 212 of the MCSIA, the FMCSA believes that this group should be considered as posing a serious safety risk to the motoring public.

The FMCSA has considered the accident information presented by the ABA, the Amalgamated Transit Union, Casa de Proyecto Libertad, and Greyhound and believes the information is an indicator that there may be problems with the safety management controls of these CMV operators. This data is discussed in the preamble of the final rule concerning requirements for operators of small passenger-carrying CMVs published elsewhere in today's issue of the **Federal Register**. While the data has limitations, it is alarming and suggests the need for action to improve the operational safety of this group of motor carriers.

Although all of the comments discussed above were submitted prior to the passage of the MCSIA, the implementation of section 4008 of the TEA–21 and section 212 of the MCSIA are so closely related that the comments are relevant to this rulemaking proposal. Section 212 of the MCSIA gives the agency explicit direction on how to implement the statutory change in the CMV definition provided at section 4008 of the TEA–21.

As indicated in the preamble of the final rule concerning requirements for operators of small passenger-carrying CMVs, published elsewhere in today's **Federal Register**, the agency stands by the FHWA's previously stated position that the phrase ''for compensation'' is synonymous with ''for hire'' and its April 4, 1997 (62 FR 16370, 16407), interpretation of ''for-hire motor carrier.'' The interpretation states:

> The FHWA has determined that any business entity that assesses a fee, monetary or otherwise, directly or indirectly for the transportation of passengers is operating as a for-hire carrier. Thus, the transportation for compensation in interstate commerce of passengers by motor vehicles (except in six-passenger taxicabs operating on fixed routes) [2] in the following operations would typically be subject to all parts of the FMCSRs, including part 387: Whitewater river rafters; hotel/motel shuttle transporters; rental car shuttle services, etc. These are examples of for-hire carriage because some fee is charged, usually indirectly in a total package charge or other assessment for transportation performed.

The interpretation noted above simply lays out the agency's view of its statutory authority, and the current applicability of the safety regulations to certain for-hire motor carriers.

Although the FMCSA's interpretation of ''for compensation'' remains unchanged, the agency is proposing that this rulemaking be applicable only to a subset of the for-hire motor carriers of passengers covered by the final rule concerning requirements for *all* operators of small passenger-carrying CMVs, published elsewhere in this issue of the **Federal Register**. The agency is proposing that this rulemaking be applicable only to entities that assess a fee, monetary or otherwise, directly for the transportation of passengers. Therefore, the use of small passenger-carrying CMVs for compensation by operators, such as hotel/motel shuttle transporters, rental car shuttle services, whitewater river rafters, etc., would not be subject to the safety-related operational regulations, irrespective of the distance traveled. Since these businesses do not hold themselves out to the public as providers of transportation services, the FMCSA does not intend to impose the safety-related operational regulations on them at this time. The agency requests comments on this issue.

Coverage of Camioneta Operations

Section 212 of the MCSIA requires the FMCSA to make the safety regulations applicable to camioneta operations. The statute did not include a definition of the term camioneta, but the Congress issued an explanatory statement (see 145 Cong. Rec. H12868, at H12873 (November 18, 1999)) that suggests that camioneta operations are those that involve transporting passengers from Mexico to the United States and vice versa.

The FMCSA does not have information concerning the number of motor carriers with CMV operations that fit the congressional description of camioneta. In its comments to the September 3, 1999, interim final rule and the NPRM published on the same day, the Texas Department of Public Safety described camionetas operations as those transporting passengers ''between major cities in Texas and the other southern states to and from our borders with Mexico.'' The FMCSA has analyzed detailed accident data from the National Highway Traffic Safety Administration's (NHTSA) Fatality Analysis Reporting System (FARS) and believes the accident data suggests that if there are fatal accidents involving these operators, the vast majority of the vehicles appear to be registered in the United States. While they may travel between points in Mexico and the United States, the vehicles are not necessarily based in Mexico.

Rather than drafting a rule that specifically targets, in part, vehicles that actually cross the border, the FMCSA believes section 212 should be implemented by focusing on the distance traveled. A distance-based approach would capture CMV operators that transport passengers from the U.S.-Mexico border to major cities in Texas and other States. Carriers that actually cross the border would also be covered, but only in those instances where the transportation of any of the passengers exceeds a certain distance. The distance the passengers were transported would be determined by looking at the point of origin and the destination, irrespective of which side of the U.S.-Mexico border the trip begins or ends. The FMCSA requests comments from State and local enforcement agencies on whether a distance-based approach would ensure coverage of the vast majority of camioneta operations as described by the Congress.

Coverage of Van Operations Determined To Pose Serious Safety Risks

In addition to requiring the FMCSA to make the safety-related operational regulations applicable to camioneta operations, the Congress required that the safety regulations apply to other types of small passenger-carrying CMV operations beyond commercial zones believed to pose safety concerns. The FMCSA believes that the Congress intended to extend the reach of the FMCSRs to interstate van operations where the distance traveled is comparable to that covered by intercity motor coach operations. Commenters to the previous rulemaking documents discussed above were concerned about trips between major cities in the U.S. Many of these small passenger-carrying operations appear to be the ones the Congress referred to as ''* * * vans operating in interstate commerce outside of commercial zones that have been determined to pose serious safety risks.'' With this in mind, the FMCSA believes section 212 of the MCSIA would be implemented most effectively by making the FMCSRs applicable to interstate for-hire (direct compensation only) van operations where the distance traveled exceeds a certain distance. This would result in a rule that is applicable to small passenger-carrying CMVs used to transport passengers as follows: (1) From Mexico to the U.S. and vice versa, (2) from Canada to the U.S. and vice versa, and (3) between various points in the U.S. If the distance covered meets a certain threshold, then the CMV operation would be covered. Based on the FMCSA's analysis of the accident data currently available, the agency believes the threshold should be 75 air miles (86.3 statute miles or 138.9 kilometers). A discussion of the accident data analysis is presented below.

The FMCSA believes the distance-based approach is an appropriate response to the congressional mandate that the rules be made applicable to: (1) Commercial vans commonly referred to as ''camionetas,'' and (2) small passenger-carrying CMVs operating outside of commercial zones that have been determined to pose serious safety

[2] The reference to six-passenger taxicabs operating on fixed routes was included in the guidance due to a CMV definition set forth in the ICC Termination Act of 1995 (ICCTA) Pub. L. 104–88, 109 Stat. 803, 919). The ICCTA amended the statutory definition of a CMV, by adding the words ''designed or used to transport passengers for compensation, but exclude(s) vehicles providing taxicab service and having a capacity of not more than 6 passengers and not operated on a regular route or between specified places.'' The TEA–21 definition removed this clause from the definition of CMV.

risks. The agency believes the accident data supports this approach in that the proposed rule would cover camionetas, as described by the Congress, and other CMV operations that have been determined to pose serious safety risks.

Analysis of Accident Data Concerning Large Vans

The FMCSA has reviewed accident data from the NHTSA's FARS and General Estimates System (GES) to determine the prevalence of crashes involving large vans. Generally, these databases do not enable the agency to identify accidents involving passenger-carrying vehicles designed or used to transport between 9 and 15 passengers for compensation in interstate commerce. However, the databases do provide information that could be used to generate estimates of the incidence of accidents involving large vans in general, and more specifically, fatal accidents involving large vans transporting 9 or more passengers (including the driver) at the time of the accident.

GES Data

In 1998, there were approximately 145,000 accidents involving large vans. These accidents resulted in 1,714 fatalities and approximately 244,000 injuries. This accident data includes all large vans (those designed to transport passengers, as well as those used for other purposes such as parcel delivery) and is not limited to vans being operated for compensation in interstate commerce. Nonetheless, the data are alarming in terms of the number of accidents, injuries, and fatalities associated with the operation of large vans.

FARS Data

As part of its effort to locate more detailed data concerning accident involvement of vans designed or used to transport between 9 and 15 passengers, the agency reviewed the 1998 FARS data. In 1998, there were 1,464 fatal accidents involving large vans. These accidents resulted in 1,714 fatalities. The fatal accident number includes all large vans and is not limited to vans being operated for compensation in interstate commerce. The reason for this is that the accident information is not coded in a manner that would enable the FMCSA to determine which accidents involved the operation of large vans in commerce, or more specifically, vans being operated for compensation in interstate commerce.

To better estimate the fatal accident involvement of vans most likely to have been used to transport passengers for compensation, the agency attempted to separate fatal accidents involving commuter vanpools transporting individuals to and from work from accidents likely to involve motor carriers. This was done because the agency does not consider most vanpools to be for-hire passenger carrier operations. For the purpose of this analysis, the agency assumed that vanpools usually operate in the morning and afternoon rush hours—the agency used 6 a.m. to 9 a.m. as the morning rush hour, and 4 p.m. to 7 p.m. as the evening rush hour. The use of these time frames as the morning and afternoon rush hours is consistent with the FHWA's ''Summary of Travel Trends 1995 Nationwide Personal Transportation Survey,'' FHWA–PL–00–006, December 1999. The FHWA conducts this survey to obtain information on personal travel of U.S. households with respect to why, how, when, where from, where to, how frequently, how long, and with whom.

Looking at the accidents by time of day, there were 537 fatal accidents involving large vans between the hours of 9 a.m. and 4 p.m. and 496 accidents involving these vehicles between the hours of 7 p.m. and 6 a.m. In addition, there were 102 fatal accidents during the weekends, resulting in a total of 1,135 fatal accidents not likely to involve vanpools.

When the data is examined with a focus on large vans actually transporting 9 or more people at the time of the accident, there were 58 fatal accidents in which the large van was transporting 9 or more people at the time of the accident resulting in 101 fatalities. Thirty-six of these accidents occurred during non-rush hours (20 fatal accidents between 9 a.m. and 4 p.m. and 16 fatal accidents between 7 p.m. and 6 a.m.).

Given the current coding of accident data, the FMCSA believes the only crashes for which there is certainty that the large van was designed or used to transport between 9 and 15 passengers would be those cases in which the number of occupants in the van at the time of the crash was equal to 9 or more. The agency acknowledges that there may have been a number of fatal accidents in which large vans were transporting less than 9 passengers. However, the agency does not currently have data about the number of crashes involving vehicles that were designed to transport between 9 and 15 passengers, but were being used to transport less than 9 passengers at the time of the crash. Therefore, the agency believes that in 1998 there may have been as few as 36 fatal accidents involving the operation of large van for compensation based on the number of crashes in which the vehicle was transporting 9 or more passengers at the time of the crash. The agency estimates that there may have been as many as 1,099 [3] other crashes with vehicles designed to transport between 9 and 15 passengers, but transporting less than 9 passengers for compensation at the time of the crash.

Additional FARS Analysis Using Accident Location Codes, Driver and Vehicle Information

The FMCSA reviewed the data fields in FARS to determine whether it would be possible to estimate the distance a large van may have traveled prior to being involved in the fatal accident, and if there was any way to identify those accidents most likely to have involved interstate transportation. The agency determined that FARS could provide potentially useful information to help identify the accidents most likely to have involved interstate transportation based on a comparison of data fields for the State in which the vehicle crashed, the State in which the vehicle was registered, and the State of the driver's license.

The agency estimated the approximate distance between the geographic area of the driver's residential zip code and the county and State in which the crash took place. The distances were computed for almost all fatal accidents involving a large van transporting 9 or more people at the time of the accident for calendar years 1996, 1997, and 1998. The agency operated under the assumption that the most likely trips to be considered interstate in nature are ones in which the State of registration of the vehicle and State of issuance for the driver's license differ from the State where the vehicle crashed.

There were 161 fatal accidents between 1996 and 1998 (49 crashes in 1996, 54 crashes in 1997, and 58 crashes in 1998) in which the vehicle was transporting 9 or more passengers at the time of the crash. The FARS information for seven of the accidents lacked one or more of the data items needed for the analysis. Two of the accidents involved U.S. Government vehicles and were excluded from the analysis since they would not be covered by the proposed rulemaking—the FMCSRs include an exception for transportation performed by the Federal government, a State, or

[3] This number is the result of taking the 1,135 non-rush hour fatal crashes involving large vans and subtracting the 36 non-rush hour fatal crashes in which there were 9 or more passengers onboard at the time of the crash.

any political subdivision of a State (49 CFR 390.3(f)). Five of the accidents involved Mexico-licensed drivers operating vehicles registered in the U.S. and one involved a Mexico-licensed driver operating a vehicle for which the database did not include registration information. It was not possible to complete the distance analysis for those accidents.

Of the remaining 146 fatal accidents in which the large van was transporting 9 or more people at the time of the crash, 45 of them (approximately 31 percent) appear to have been interstate trips with the crash taking place in a State other than the State where the driver was licensed, and at a distance greater than 100 statute miles from the driver's residence. The shortest distance among the likely interstate trips was just over 100 statute miles, while the longest was more than 2,100 statute miles (a trip involving a driver licensed in California, a large van registered in Oregon, and a fatal crash in Louisiana).

Forty-seven of the 146 fatal accidents (approximately 32 percent) appear to have been intrastate trips with the fatal accident taking place in the State where the driver was licensed and where the vehicle was registered, and at a distance greater than 100 statute miles from the driver's residence. The shortest distance among the likely intrastate trips was just over 100 statute miles, while the longest was more than 550 statute miles (a trip involving a driver licensed in California, a large van registered in California, and a fatal crash in California).

Fifty-four of the accidents (37 percent) occurred within 100 statute miles of the driver's residence with only a small percentage (seven out of 54 crashes, approximately 13 percent) involving what appears to be an interstate trip.

Overall, approximately 63 percent of the fatal accidents involving large vans occurred between 100 and 2,200 statute miles from the driver's residence with the longest distances linked typically to the trips that were most likely interstate in nature.

It is not possible to determine the distance the driver may have traveled to get to the work-reporting location, or to determine whether the van was operated by an individual working from home. However, the FMCSA has factored into the analysis a maximum distance of 25 statute miles between the driver's residence and a possible work-reporting location. The FHWA's ''Summary of Travel Trends 1995 Nationwide Personal Transportation Survey,'' cited above, indicates that the average commute to work among the individuals participating in the survey was 11.63 miles. To decrease the likelihood of underestimating the average of commuting distances of drivers of small passenger-carrying CMVs, the FMCSA is using an estimate of 25 miles, a little more than twice the average in the nationwide survey. When the estimated 25 statute miles for commuting to work is deducted from the estimates of the distance between the driver's residence and the crash location, the result is an estimate of 75 statute miles as the distance that the driver may have traveled from the work reporting location to the crash site.

For simplicity, the agency would use 75 air miles which is equivalent to 86.3 statute miles because the motor carrier industry and enforcement community have experience using air miles, inasmuch as the current hours-of-service rules include an exemption from the records of duty status requirement for drivers operating within a 100 air-mile radius of their work-reporting location.

Based on the preceding analysis, the FMCSA believes a mileage threshold of 75 air miles (86.3 statute miles or 138.9 kilometers) should be used for determining the applicability of the safety regulations to for-hire operations of small passenger-carrying vehicles operating in interstate commerce. The analysis indicates that approximately 63 percent of 146 fatal accidents in which a large van was actually transporting 9 or more occupants at the time of the crash involved drivers that may have traveled more than 75 statute miles from their work-reporting location. Although the agency does not have data to determine which vans were being used in commerce (either interstate or intrastate), or the actual distances from drivers' work reporting locations to the site of the fatal crash, the agency believes the data are compelling and suggest the need for action to improve the safety of operation of these vehicles. The agency requests comments on the methodology used to determine the distance and/or mileage threshold and whether air miles or statute miles should be used.

Discussion of the Estimated Population of For-Hire Van Operations

The FMCSA is proposing that the FMCSRs be made applicable to small passenger-carrying CMV operations that are directly compensated for long-haul interstate transportation. Generally, these same operations are already subject to the agency's licensing (i.e., operating authority) and insurance requirements. To get an estimate of the number of motor carriers of passengers that are likely to be affected by this rulemaking the FMCSA reviewed its database of for-hire motor carriers of passengers that have interstate operating authority. As of February 2000, there were 1,648 for-hire motor carriers of passengers with active authority to operate CMVs with a seating capacity of 15 passengers or less. Each of these motor carriers has on file with the FMCSA proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. This number does not include motor carriers that may have pending applications for operating authority, passenger carriers shown as inactive because their authority was revoked for failure to maintain evidence of the required minimum levels of financial responsibility, or private motor carriers of passengers. This number may also overstate the affected population since some of the licensed carriers may be exclusively operating equipment carrying less than 9 passengers (e.g., luxury sedans or limousines designed to transport less than 9 passengers). Therefore, using the information from the FMCSA's database of motor carriers of passengers, the agency believes a reasonable estimate of the population of motor carriers that could be subject to this rulemaking is approximately 1,648. The agency requests comments on this issue.

Discussion of Proposal

The FMCSA is proposing to revise the FMCSRs to require that motor carriers operating CMVs that are designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation in interstate commerce (including transportation between points in Canada and Mexico, and points in the U.S.) comply with the regulations contained in 49 CFR parts 390, 391, 392, 393, 395 and 396, when the transportation of any passenger covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers). This means that these motor carriers would be required to ensure that each of their drivers meet all of the minimum qualifications for interstate CMV drivers, including physical qualifications, prescribed in part 391, and maintain records to document compliance. In addition, the driver disqualification provisions of 49 CFR 391.15 would also be applicable. The driving rules of part 392 would be applicable and the vehicles would be required to meet all applicable rules concerning parts and accessories necessary for safe operation covered under part 393.

Each motor carrier would be required to have a systematic inspection, repair,

and maintenance program for the CMVs it operates, and to ensure that vehicles are in safe and proper operating condition at all times. They would also be required to maintain records to document compliance with these rules.

Motor carriers would be required to ensure that each vehicle is inspected at least once every 12 months by a qualified inspector/mechanic and that any motor carrier employee that is responsible for the adequacy of any brake-related inspection, repair, or maintenance work meets certain minimum qualifications. They would also be required to maintain records to document compliance with these rules.

In addition to the above, motor carriers must ensure that their drivers comply with the hours-of-service requirements. Drivers would not be allowed to drive more than 10 hours after eight consecutive hours off duty or operate CMVs after being on duty more than 15 hours, following eight consecutive hours off duty. Furthermore, drivers would not be allowed to drive after being on duty 60 hours in any seven consecutive days if the motor carrier does not operate CMVs every day of the week (60-hour rule), or after being on duty 70 hours in any eight consecutive days if the motor carrier operates CMVs every day of the week (70-hour rule). For drivers that operate beyond a 100 air-mile radius of the normal work-reporting location, a record of duty status (log book) would be required to document the number of hours on duty and the number of hours driving.

The FMCSA is **not** (emphasis added) proposing to make the commercial driver's license and controlled substances and alcohol testing requirements applicable to operators of small passenger-carrying CMVs, because neither section 4008 of the TEA–21 nor section 212 of the MCSIA amend the statutory definition of CMV used for those programs (49 U.S.C. 31301). Consequently, the passenger-carrying threshold for CDL and controlled substances and alcohol testing requirements remains at 16 (including the driver).

The FMCSA acknowledges that most of the rules that would be made applicable to operators of small passenger-carrying CMVs were developed to ensure safety in the motor coach and trucking industries. However, given the type of passenger-carrying operation that the agency proposes to regulate, the FMCSA believes these requirements are appropriate. The van operations that would be regulated have similar operational characteristics as intercity motor coach businesses and should be required to meet similar standards of safety. The agency requests comments on this issue.

Implementation Schedule

The FMCSA is proposing that motor carriers be required to comply with the safety requirements 90 days after the effective date of the final rule. This means that motor carriers would have approximately 120 days after the date of publication of the final rule to comply with the rules. The agency believes this is sufficient time for the motor carriers that would be affected to establish and implement safety management controls to achieve compliance with the FMCSRs. Furthermore, the agency believes that the FARS and GES data suggest that it is in the public interest to require compliance with the FMCSRs as soon as practicable. The FMCSA requests comments on this issue.

Relationship Between Proposed Rules and 49 CFR Part 398, Transportation of Migrant Workers

The FMCSA has reviewed the proposed requirements and determined that some of the motor carriers that would be covered by this rulemaking may currently be subject to the agency's rules for transporters of migrant workers. Currently, in 49 CFR part 398 of the FMCSRs, the agency prescribes certain requirements for motor carriers transporting migrant workers for a total distance of more than 75 miles in interstate or foreign commerce. Section 398.1 defines a migrant worker as any individual proceeding to or returning from employment in agriculture as defined in section 3(f) of the Fair Labor Standards Act of 1938, as amended (29 U.S.C. 203(f)) or section 3121(g) of the Internal Revenue Code of 1986 (26 U.S.C. 3121(g)). The term ''carrier of migrant workers by motor vehicle'' means any person, with certain limited exceptions, who transports in interstate or foreign commerce at any one time three or more migrant workers to or from their employment by any motor vehicle other than a passenger automobile or station wagon.

Carriers of migrant workers that are directly compensated for their transportation services and that use vehicles designed or used to transport between 9 and 15 passengers would be covered by the proposed rules which are generally more stringent than the requirements of part 398. One example where this is not the case is § 398.6, which prohibits motor carriers from permitting or requiring drivers to operate vehicles for more than 10 hours in any 24-hour period, unless the driver is given eight hours rest immediately following the 10 hours driving time. This daily limit is more restrictive than the comparable provision for drivers of larger CMVs (§ 395.3(a)(1)), which currently allows a driver to drive up to 16 hours out of 24 in certain circumstances.

Although compliance with part 395 would result in a less restrictive requirement in this instance, the FMCSA does not believe this deviation is significant in terms of highway safety. The restriction in part 398 is based only on the amount of time the driver operates the vehicle for the transporter of migrant workers and does not take into account other activities that may affect the driver's fitness for duty and level of alertness. Part 395 includes rules to prohibit driving after being on-duty (both driving time and time spent performing other tasks) for more than 15 hours following at least eight consecutive hours off-duty. Part 395 also takes into account any compensated work, irrespective of whether the work was performed for the motor carrier. For example, if the driver has a part-time job, the time spent on the part-time job must be factored into the calculations to determine the available driving time. The FMCSA believes that overall, part 395 is more stringent than part 398 and that compliance with all of the requirements of part 395 would improve safety.

The FMCSA believes that it is appropriate to impose tougher standards on carriers of migrant workers if their operations are conducted in a manner similar to intercity motorcoach businesses. The agency would amend § 398.2, Applicability, of the transporters of migrant worker rules to make it clear to the affected motor carriers when they must comply with the same FMCSRs as intercity motor coach operations. The agency requests comments on this issue.

Applicability of Safety Fitness Procedures to Operators of Small Passenger-Carrying CMVs

Part 385 of the FMCSRs establishes procedures to determine the safety fitness of motor carriers, to assign safety ratings, to take remedial action when required, and to prohibit motor carriers receiving a safety rating of ''unsatisfactory'' from operating a CMV. If the proposed requirements are adopted, motor carriers operating small passenger-carrying CMVs would be covered by the same safety fitness procedures and standards used to evaluate other interstate motor carriers. This means that motor carriers affected by this rulemaking would be subject to compliance reviews and receive safety

ratings. For those that receive an ''unsatisfactory'' safety rating, they would be prohibited from operating CMVs to transport passengers in interstate commerce. In addition, these motor carriers would be ineligible to contract or subcontract with any Federal agency for transportation of passengers in interstate commerce. The agency would amend § 385.1, Purpose and scope, to reflect the new passenger-carrying threshold for the applicability of the FMCSRs and the safety fitness procedures. The agency believes the current safety fitness procedures should be used and requests comments on this issue.

Effect of Proposed Rule on the Motor Carrier Safety Assistance Program (MCSAP)

The MCSAP is a Federal grant program that provides financial assistance to States to reduce the number and severity of accidents and hazardous materials incidents involving CMVs. The goal of the MCSAP is to reduce CMV-involved accidents, fatalities, and injuries through consistent, uniform, and effective CMV safety programs. The MCSAP sets forth the conditions for participation by States and local jurisdictions and promotes the adoption and uniform enforcement of safety rules, regulations, and standards compatible with the FMCSRs and Federal Hazardous Materials Regulations (HMRs) for both interstate and intrastate motor carriers and drivers. The MCSAP rules are codified in 49 CFR parts 350 and 355.

On March 21, 2000 (65 FR 15092), the FMCSA published a final rule revising the MCSAP to comply with the provisions of the TEA–21. This action broadened the scope of the MCSAP beyond enforcement activities and programs by requiring participating States to assume greater responsibility for improving motor carrier safety. These rules now require States to develop performance-based plans reflecting national priorities and performance goals, revise the MCSAP funding distribution formula, and create a new incentive funding program.

Section 350.201 establishes the conditions States must meet to qualify for basic program funds. Those conditions include assuming responsibility for improving motor carrier safety and adopting and enforcing State safety laws and regulations that are compatible with the FMCSRs (49 CFR parts 390–397) and the HMRs, except as may be determined by the Federal Motor Carrier Safety Administrator to be inapplicable to a State enforcement program.

Section 350.341 establishes the variances from the FMCSRs allowed in State laws and regulations. These variances apply only to motor carriers, CMV drivers, and CMVs engaged in intrastate commerce and not subject to Federal jurisdiction. Under the current variances, a State may exempt a CMV from all or part of its laws or regulations applicable to intrastate commerce, provided that neither the gross vehicle weight, gross vehicle weight rating, gross combination weight, nor gross combination weight rating of the vehicle equals or exceeds 11,801 kilograms (26,001 pounds). However, a State may not exempt a CMV from such laws or regulations if the vehicle: (1) transports hazardous materials requiring a placard; or (2) is designed or used to transport 16 or more people, including the driver.

As a condition of participation in the MCSAP, States would be required to adopt and enforce compatible regulations concerning the interstate operation of small passenger-carrying CMVs if the FMCSA adopts the proposed rules. The agency does not intend to amend the variances under § 350.341, which means that the States would not be required to adopt and enforce regulations concerning the intrastate operation of small passenger-carrying CMVs. The FMCSA would encourage the States to adopt and enforce intrastate laws and regulations concerning the operation of these CMVs if the accident data warrants such action.

Based on the agency's analysis of the FARS data for 1996, 1997, and 1998 approximately 32 percent (51 out of 161) of all fatal crashes involving large vans transporting 9 or more passengers at the time of the accident during the past three years occurred in just three States (California (24 fatal accidents), Texas (15 fatal accidents), and Florida (12 fatal accidents)). This suggests that it is not necessary for each State to adopt and enforce intrastate regulations concerning small passenger-carrying CMVs. However, States such as California, Texas, and Florida should give strong consideration to adopting and enforcing intrastate regulations given the FARS data.

The FMCSA requests public comment on the feasibility of making the adoption and enforcement of compatible safety regulations applicable to small passenger-carrying CMVs operated in interstate commerce a condition of receiving MCSAP funds. The agency also requests comments on whether the variances should be amended to require the adoption and enforcement of intrastate regulations applicable to the intrastate operation of these types of vehicles.

Itemization of the Estimated Costs of Imposing Safety-Related Requirements

The FMCSA has attempted to evaluate the potential costs of the proposed rule. The agency has considered currently available data concerning the number of affected motor carriers, CMVs, and drivers. As indicated earlier, the agency estimates that this rulemaking could affect up to 1,648 for-hire motor carriers of passengers with active authority to operate CMVs with a seating capacity of 15 passengers or less. Each of these motor carriers has on file with the FMCSA proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. This number does not include the following: (1) Motor carriers that may have pending applications for operating authority; (2) passenger carriers shown as inactive because their authority was revoked for failure to maintain evidence of the required minimum levels of financial responsibility; (3) private motor carriers of passengers; or (4) carriers which also operate larger vehicles, as well as smaller vehicles. This number may also overstate the population of affected carriers since some of the licensed carriers may be exclusively operating equipment carrying less than 9 passengers.

With regard to the number of drivers and vehicles that would be covered by the safety regulations, the FMCSA does not have a definitive source for this information at this time because for-hire small passenger motor carriers are not required to complete the Form MCS–150, Motor Carrier Identification Report, which is used to gather information about motor carriers subject to the FMCSRs. As a result of the final rule concerning requirements for operators of small passenger-carrying CMVs published elsewhere in today's **Federal Register**, the agency will begin to gather data to better estimate the number of affected carriers, drivers, and vehicles.

In the absence of other sources of information, the agency believes certain estimates provided by the International Taxicab and Livery Association (ITLA) may be useful in helping to estimate the number of drivers and vehicles that would be covered by this proposal. In comments submitted in response to the FHWA's August 5, 1998, advance notice of proposed rulemaking (63 FR 41766) on the subject of safety requirements for the operators of small passenger-carrying CMVs, the ITLA estimated that there are 74,000 vans nationwide being operated for compensation. The ITLA

estimated that van fleets average less than 10 vans. In addition, the ITLA estimated that if the agency made the FMCSRs applicable to the operation of small passenger-carrying vehicles, approximately 14,000 companies, 125,000 vehicles, and 165,000 drivers would be covered.

The FMCSA believes most of the estimates provided by the ITLA appear to be representative of businesses that would not be covered by this proposal in that this rulemaking would be applicable to long-haul van operations and not for-hire operations that are local in nature. However, the agency will use the ITLA's estimate of the number of vehicles per fleet (10 vans) as a baseline estimate for the number of vehicles that would be covered. This means that approximately 16,500 small passenger-carrying vehicles (10 vans per fleet × 1,648 for-hire operations) would be covered under the FMCSRs.

The agency estimates that the number of drivers would be a fraction of the 165,000 drivers in the ITLA's estimate since the proposal is targeted at drivers in the long-haul segment of the small passenger carrier industry. The agency believes the total number of drivers would be approximately 18,300 (165,000 divided by nine) since the number of motor carriers currently operating as for-hire motor carriers of passengers with small passenger-carrying vehicles is approximately one-ninth of the ITLA's estimate of all for-hire motor carriers.

Earnings of Commercial Van Drivers, Mechanics, and Supervisors

In order to evaluate accurately the cost implications of the proposed rule, the FMCSA reviewed earnings information from the U.S. Department of Labor. The FMCSA used information from the ''Occupational Outlook Handbook,'' 2000–01 Edition, Bulletin 2520. The earnings information is being used to determine the costs of requiring motor carrier employees and individuals who perform services for motor carriers to complete certain records that would not be completed in the normal course of business and to perform certain tasks associated with complying with the proposed requirements.

The agency has decided preliminarily to use the earnings figures for chauffeurs because the drivers in question generally do not meet the qualifications requirements for intercity bus drivers. The median hourly earnings of taxi drivers and chauffeurs, excluding tips, were $7.48 in 1998. The middle 50 percent earned between $6.02 and $9.79 an hour. The lowest 10 percent earned less than $5.55 and the highest 10 percent earned more than $12.44 an hour. For the purpose of preparing cost estimates for imposing safety-related operational rules, the agency will use $12.44 an hour to decrease the likelihood of underestimating the impact of this rulemaking.

The ''Occupational Outlook Handbook'' shows the estimated median hourly earnings for automotive mechanics and service technicians, including commission, were $13.16 in 1998. The middle 50 percent earned between $10.02 and $17.14 an hour. The lowest 10 percent earned less than $7.44 and the highest 10 percent earned more than $21.25 an hour. For the purpose of preparing cost estimates for this rulemaking the agency is using $21.25 an hour.

The FMCSA is using $22 an hour as the estimated earnings for supervisors and managers of transportation. The ''Occupational Outlook Handbook'' did not include a specific category for transportation supervisors so the agency is operating under the assumption that these supervisors are paid more than the individuals they supervise. The agency made an estimate that the supervisors are paid $ 0.75 an hour more than the service technicians, or $22. The agency requests comments on this estimate.

Medical Examination and Certification

Drivers subject to the proposed rule would be required to obtain a medical examiner's certificate. The FMCSA estimates that the average cost of a comprehensive medical examination is approximately $300. This cost includes an estimate of the driver's out-of-pocket expenses or co-payment and an estimate of the amount the driver's health insurance company would pay the medical examiner. Since a medical examiner's certificate is usually valid for 24 months, the FMCSA estimates the prorated annual cost of CMV driver medical certifications to be approximately $2,745,000 (($300 per exam per driver) × (18,300 drivers) = $5,490,000 every two years) based on an estimated 18,300 drivers who would be subject to the proposed rule.

Generally, it takes a medical examiner (*i.e.,* a physician, doctor of osteopathy, physician assistant, advance practice nurse, or doctor of chiropractic) about eight minutes to complete a medical examination form and one minute to fill out the medical certificate. Based on the $132,000 median annual earning of a general/family practice physician listed in the Department of Labor's ''Occupational Outlook Handbook'' and an estimated 2,080 hours of work per year, the earnings are equal to approximately $63 an hour. The estimated costs to the industry for having medical examiners complete the required paperwork would be $172,935 ($63 an hour × (9 minutes × 1 hour per 60 minutes) × 18,300 medical exams performed for drivers). This is the cost every two years. The cost each year would be $86,467.50.

Therefore, the total annual costs for the physical exam would be approximately $2,831,467. Comments on this estimate are welcomed.

Driver Qualification Files

The FMCSA estimates that the operators of small passenger-carrying CMVs would have to create 18,300 driver qualifications files during the first year and create approximately 2,379 new files (13 percent of 18,300) each year thereafter as a result of driver turnover, retirement, etc. The estimate of driver turnover is the same used for previous information collection burden estimates for driver qualifications files. This means that motor carriers would be responsible for maintaining approximately 15,921 existing files every year after the first year this rule is in effect and creating 2,379 new files.

The creation of a single, complete driver qualification file involves an annual expenditure of approximately 24 minutes, which is the sum of 20 minutes of paperwork by a safety director, driver supervisor, or equivalent position, and 4 minutes of paperwork by a driver. For the first year, the cost would be $148,793 ((0.33 hours per driver employed × 18,300 drivers × $22 an hour per supervisor) plus (0.07 hours per driver employed × 18,300 driver × $12.44 an hour per driver)), or $132,858 for the time supervisors spend on this task and $15,935 for drivers' time. For subsequent years the cost for creating new driver qualification files would be $19,342 ((0.33 hours per driver employed × 2,379 drivers × $22 an hour per supervisor) plus (0.07 hours per driver employed × 2,379 driver × $12.44 an hour per driver)), or $17,271 for the time supervisors spend on this task and $2,071 for drivers' time.

Each driver is required to furnish his/her employing motor carrier with a list of traffic violations. The FMCSA estimates that it takes a driver approximately two minutes to complete the list. Motor carriers are required to conduct an annual review of their drivers' records. The agency estimates that it takes approximately five minutes per driver to complete this task. The cost of complying with the list of traffic violations is $5,941 (15,921 drivers × (0.03 hours per driver) × ($12.44 an hour

for a driver)). The cost of complying with the annual review is $28,021 ((15,921 drivers) × (0.08 hours per driver) × ($22 an hour for a supervisor)). The total cost per year for the annual list of violations and the review of the driving record is $33,962.

Therefore, the estimated cost for driver qualification files is $148,793 for the first year carriers would be required to comply with the safety-related operational provisions of the FMCSRs, and $59,245 for each subsequent year ($19,342 for creating new qualification files, $5,941 for the list of traffic violations, and $33,962 for the driving record review). The agency requests comments on these estimates.

Records of Duty Status

As indicated above the FMCSA believes the proposed rule would be applicable to 18,300 drivers. It is estimated that each driver would spend approximately 2.5 minutes per workday to complete a record of duty status and work an average of five workdays per week and 50 weeks per year. The information collection burden for completing the record of duty status would be approximately 190,624 hours (18,300 drivers × (2.5 minutes per day × 1 hours per 60 minutes) × (5 days per week × 50 weeks per year). The estimated total cost burden related to the record of duty status is approximately $2,371,374 based on an estimated time burden of 190,624 hours at $12.44 an hour for drivers. This time and cost burden estimate takes into consideration two weeks of sick/vacation leave for these drivers.

The FMCSA estimates that each motor carrier that is affected by this rule would have a supervisor responsible for reviewing its drivers' records of duty status and that the supervisor would spend approximately one hour per week reviewing these records to ensure compliance with the hours-of-service rules. Based on an estimate of 1,648 motor carriers operating small passenger-carrying CMVs, and one supervisor per motor carrier, the agency estimates a time burden of 1,648 hours per week for 50 weeks, for a total of 82,400 hours. Using the earnings estimate presented above, the annual cost would be $1,812,800.

Therefore, the total costs for requiring motor carriers to comply with part 395 would be $4,184,174. We invite comments on this issue.

Vehicle Inspection, Repair, and Maintenance

The FMCSA estimates the various recordkeeping requirements related to vehicle inspection, repair, and maintenance would involve an estimated total annual expenditure of 12 hours and 57 minutes per CMV (48 minutes for systematic inspection, repair, and maintenance; 724 minutes for driver vehicle inspection reports; and 5 minutes for periodic inspection). Evidence of an individual's qualifications to perform periodic vehicle inspections must be retained by the motor carrier. Evidence of an individual's qualifications to be a brake inspector must be retained also. The creation of these two types of qualification evidence involves an estimated one-time, non-recurring expenditure of 5 minutes by a safety director, driver supervisor, or equivalent position for each type of qualification.

The systematic inspection, repair, and maintenance records would be completed by a mechanic. The periodic inspection records would also be prepared by a mechanic. The estimated hourly earnings for a mechanic is $21.25 as indicated above. If the mechanic must spend approximately 53 minutes per year per vehicle, the cost per year per vehicle for recordkeeping would be approximately $18.77. If there are 16,500 vehicles that would be covered by the proposed rule, the total cost for systematic inspection, repair, and maintenance, and periodic inspection records would be $309,718.

Drivers would prepare vehicle inspection reports at the end of each workday. It is estimated that each driver would spend 724 minutes per year, or 12.06 hours per year completing the paperwork. Using the earnings estimate of $12.44 an hour, the cost for having drivers prepare vehicle inspection reports would be $150 per driver per year. Based on an estimate of 18,300 drivers, the cost per year for the industry would be $2,747,000.

Finally, looking at the cost for inspector qualifications, the FMCSA believes the paperwork would be completed by a supervisor. Using the earnings estimate of $22 an hour, and an information collection burden of 10 minutes (five minutes for each certification of qualifications), the cost per carrier would be $3.66. The total non-recurring cost would be approximately $6,050.

Therefore, the estimated total cost burden related to the vehicle inspection, repair, and maintenance recordkeeping is approximately $3,057,000 per year.

Total Costs and Qualitative Estimate of Benefits

Costs

The sum of all estimated costs of requiring operators of small passenger-carrying CMVs to comply with parts 391, 395, and 396 is approximately $10,221,000 for the first year and $10,073,000 per year thereafter. A summary of the first-year costs is presented below.

Summary of First-year Costs To Comply With the FMCSRs

$2,831,467 for medical exams
$148,793 for driver qualifications files ($59,245 subsequent years)
$4,184,174 for hours of service recordkeeping
$3,057,000 for inspection, repair, and maintenance
Total: $10,221,000

Benefits

The FMCSA is not able to quantify the benefits at this time because the agency does not have detailed accident causation data. However, the agency believes that operational safety could be improved through compliance with the FMCSRs. The agency believes the benefits of this rulemaking would outweigh the estimated costs. The benefit of preventing as little as one-half percent (about six accidents) of the 1,135 non-rush hour fatal accidents involving large vans during 1998 would outweigh the estimated costs. This is especially the case when consideration is given to the injury and property-damage only accidents that occur annually.

The FMCSA has considered the accident information presented by the American Bus Association, the Amalgamated Transit Union, Casa de Proyecto Libertad, and Greyhound Lines, Inc. to FMCSA Docket Nos. FMCSA–97–2858 and 99–5710 (formerly FHWA Docket Nos. FHWA–97–2858 and 99–5710), the rulemaking regarding operators of small passenger-carrying CMVs within the U.S. The agency has also considered data from the GES and the FARS. The data suggests that there may be serious safety management control problems with some commercial van operations that transport passengers for compensation in interstate commerce. The application of the FMCSRs to these operations should help to reduce the incidence of crashes involving large vans thereby reducing to some extent the number of fatalities and injuries.

FMCSA Safety-Performance Study of Camionetas

The FMCSA is nearing completion of a safety-performance and industry characteristics study of motor carriers operating small passenger-carrying CMVs for compensation across the U.S.-Mexico border. This action was taken to

learn more about a segment of the motor carrier industry that has never been subject to safety regulatory oversight by the FMCSA. The study will enable the agency to: Better understand the operational characteristics of camionetas; estimate the number of carriers engaged in these operations; assess the condition of some of the vehicles typically used by these carriers; assess the nature and extent of their operational safety problems; and learn more about the reasons customers select camioneta operations for their transportation needs as opposed to motorcoach operations. The information and data generated by the study will be used to help the agency make adjustments, if necessary, to the regulatory program that would be imposed through this rulemaking. The information and data may also help to validate the economic impact analysis of the regulations on camionetas, develop an outreach campaign to make them aware of the new regulatory responsibilities, and develop enforcement strategies by Federal and State authorities.

Rulemaking Analysis and Notices

All comments received before the close of business on the comment closing date indicated above will be considered and will be available in the docket at the above address. Comments received after the comment closing date will be filed in the docket and will be considered to the extent practicable. In addition to late comments, the FMCSA will also continue to file relevant information in the docket after it becomes available after the comment period closing date. Interested persons should continue to examine the docket for new material.

Executive Order 12866 (Regulatory Planning and Review) and DOT Regulatory Policies and Procedures

The FMCSA has determined that this rulemaking action is a significant regulatory action within the meaning of Executive Order 12866 and significant within the meaning of Department of Transportation regulatory policies and procedures because of the substantial public interest concerning the possible extension of the applicability of the FMCSRs to a larger population of for-hire motor carriers of passengers. This proposed rule would require that operators of vehicles designed or used to carry between 9 and 15 passengers (including the driver) for direct compensation, in interstate commerce comply with the following rules when the transportation of any passenger covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers): 49 CFR part 391, Qualifications of drivers; 49 CFR part 392, Driving of commercial motor vehicles; 49 CFR part 393, Parts and accessories necessary for safe operation; 49 CFR part 395, Hours of service of drivers; and 49 CFR part 396, Inspection, repair, and maintenance.

Executive Order 12866 requires that regulatory agencies assess both the costs and benefits of intended regulations and proposed regulations on the basis that the benefits justify the costs. Based upon the information above, the agency anticipates that the economic impact associated with this rulemaking action would be $10,221,000 for the first year, and $10,073,000 for each subsequent year. The benefit of preventing as few as one-half percent (about six accidents) of the 1,135 non-rush hour fatal accidents involving large vans during 1998 would outweigh the estimated costs. The agency estimates that each fatality prevented would be equivalent to a benefit of $2.7 million. Preventing six single-fatality accidents per year would result in at least $16.2 million in benefits per year. Additional benefits would be achieved through reductions in injuries and property-damage only accidents involving small passenger-carrying CMVs.

For purposes of Executive Order 12866, this rulemaking does not impose an economic burden greater than $100 million on these motor carriers. Therefore, a full regulatory evaluation is not necessary.

Regulatory Flexibility Act

In compliance with the Regulatory Flexibility Act (5 U.S.C. 601–612), the FMCSA has considered the effects of this regulatory action on small entities and determined that this proposed rule would not affect a substantial number of small entities, but would have a significant impact on them.

The FMCSA is proposing that motor carriers operating CMVs, designed or used to transport between 9 and 15 passengers, in interstate commerce be made subject to the safety-related operational FMCSRs when they are directly compensated for such services, and the transportation of any of the passengers covers a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers). These motor carriers would be required to comply with 49 CFR parts 390, 391, 392, 393, 395, and 396. If most or all of these businesses are classified as small businesses by the Small Business Administration (SBA), the rule could affect approximately 1,648 small entities. However, some of these small entities may be foreign-based motor carriers that the agency is not required to include in the Regulatory Flexibility Act analysis. To avoid underestimating the potential impact on small entities, the FMCSA is using an estimate of 1,648.

This estimate is based on the current number of for-hire motor carriers of passengers with active authority to operate CMVs with a seating capacity of 15 passengers or less. Each of these motor carriers has on file with the FMCSA proof of financial responsibility at the minimum level required for the operation of vehicles designed to transport less than 16 passengers. This number does not include the following: (1) Motor carriers that may have pending applications for operating authority; (2) passenger carriers shown as inactive because their authority was revoked for failure to maintain evidence of the required minimum levels of financial responsibility; (3) private motor carriers of passengers; or (4) carriers which also operate larger vehicles, as well as smaller vehicles. This number may also overstate the population of affected carriers since some of the licensed carriers may be exclusively operating equipment carrying less than 9 passengers. Therefore, using the information from the FMCSA's database of motor carriers of passengers, the agency believes a reasonable estimate of the population of motor carriers that could be subject to this rulemaking is approximately 1,648.

As indicated earlier, the FMCSA estimates that the sum of all estimated costs of requiring operators of small passenger-carrying CMVs to comply with 49 CFR parts 391, 395, and 396 is approximately $10,221,000 for the first year and $10,073,000 per year thereafter. If the costs of the rulemaking are distributed evenly among these 1,648 motor carriers, the costs per carrier would be approximately $6,200 for the first year the requirements are in effect, and a little more than $6,100 per year thereafter. A summary of the estimated first-year costs per motor carrier is presented below.

Summary of First-year Costs Per Motor Carrier To Comply With the FMCSRs

$1,718 for medical exams
$90 for driver qualifications files ($36 subsequent years)
$2,539 for hours-of-service recordkeeping
$1,855 for inspection, repair, and maintenance
Total: $6,202

The actual costs that each individual fleet would experience depends on the number of drivers employed and the number of small passenger-carrying

CMVs operated. The above estimates are intended to serve as a baseline of 10 CMVs per fleet and about 11 drivers per business. Driver-related costs (i.e., driver qualifications, hours-of-service) for each business would decrease or increase as the number of drivers employed decreases below the baseline or increases above the baseline. The same holds true for vehicle-related costs.

The FMCSA has reviewed data from the SBA to determine the typical revenues for a motor carrier in the intercity and rural bus transportation segment of the industry. This category description appeared to be similar to the types of motor carrier operations that would be covered by this rulemaking. The SBA's 1997 ''Employer Firms, Employment and Estimated Receipts by Employment Size of Firm'' tables separated the firms into three groups: those with less than 20 employees, those with less than 500 employees, and those with 500 or more employees. The FMCSA focused on the group with less than 20 employees to be consistent with the agency's estimate of the number of drivers employed by each of the 1,648 motor carriers likely to be affected by this rule. The SBA data indicated there are 145 firms in this category with combined revenues of $41,793,000. For the purpose of this analysis, the revenues for the businesses in this group were divided by the number of firms resulting in an estimate of $288,227 in revenues per year for each carrier [($41,793,000/145 firms) = $288,227]. The agency requests comments on the annual revenues of operators of small passenger-carrying CMVs.

The agency notes that if the revenue estimate is considered accurate, then a comparison of that estimate with the employee earnings figures presented earlier, and the estimate of 11 drivers per business, suggests that the drivers are more likely to receive $9.79 an hour, rather than $12.44 an hour.

The costs per carrier associated with this rule would, on average, be approximately 2.2 percent of their revenues [(($6,200 costs per carrier)/ ($288,227 revenues per carrier)) × 100 = 2.2 percent]. For motor carriers with a profit margin greater than 2.2 percent, the rule would decrease their profits but the businesses would maintain some level of profit. For motor carriers with profit margins of 2.2 percent or less, the rule could result in the failure of the business.

The FMCSA does not have data on the profit margins of the 1,648 motor carriers likely to be impacted by the rule or more precise information about their revenues. Also, the agency does not have sufficient data about these motor carriers to determine the distribution of drivers and vehicles (*e.g.,* the number of carriers with 1 to 5 vehicles, the number of carriers with 6 to 10 vehicles, the number of carriers with 11 to 20 vehicles, etc., and similar data for the number of drivers) to make more precise its estimates concerning revenues. However, the agency believes it is appropriate to consider all 1,648 motor carriers of passengers likely to be affected by this rulemaking to be small entities to avoid underestimating the impact this rule will have on them. The agency believes the estimates presented above are reasonable given the limited information available about this segment of the motor carrier industry. Therefore, the agency has made a preliminary determination that this rule would not affect a substantial number of small entities. However, it would have a significant impact on some of these 1,648 small entities, especially in those cases where the profit margins are approximately 2.2 percent or less.

The FMCSA has considered the comments to the previous rulemaking documents concerning the regulation of small passenger-carrying CMVs and believes this group of motor carriers appears to provide an important service to its clients. These motor carriers provide services to individuals for whom motor coach services are not available, those who may not be able to afford to use motor coach operators, or individuals who choose, for whatever reason, not to use motor coach operators for their intercity travel. The agency believes the industry is very important to those who rely on them. There is a possibility for failure of some small passenger-carrying CMV operations, especially those with profit margins of 2.2 percent or less. However, the number of failures among the estimated 1,648 motor carriers operating small passenger-carrying CMVs is expected to be small. Therefore, the agency believes there could be a small degree of disruption in the services provided by small passenger-carrying CMV operations that are not capable of putting into place the safety management controls necessary to achieve compliance with 49 CFR parts 390, 391, 392, 393, 395, and 396.

The FMCSA has considered other regulatory alternatives as described earlier and made a preliminary determination that this action is necessary to fulfill section 212 of the MCSIA and respond to the safety problem indicated by the GES and the FARS data. It is unlikely that a proposal for less stringent requirements would have the same potential for improving the safety of operations of these CMVs.

Accordingly, the FMCSA has considered the economic impacts of the requirements on small entities and certifies that this rule would not have a significant economic impact on a substantial number of small entities.

Executive Order 12372 (Intergovernmental Review)

Catalog of Federal Domestic Assistance Program Number 20.217, Motor Carrier Safety. The regulations implementing Executive Order 12372 regarding intergovernmental consultation on Federal programs and activities do not apply to this program.

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), Federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct, sponsor, or require through regulations. The FMCSA has determined that this proposal contains collection of information requirements for the purposes of the PRA. These requirements, when made final, could impact four currently-approved information collections. The FMCSA is proposing that motor carriers operating CMVs designed or used to transport 9 to 15 passengers be required to meet the recordkeeping requirements of 49 CFR parts 391, 395, and 396.

Drivers of such CMVs would be required to meet the medical examination and certification requirements at 49 CFR part 391, subpart E. The information collection requirements related to that subpart have been approved by the OMB under provisions of the PRA and assigned the control number of 2126–0006 which is currently due to expire on October 31, 2003. The FMCSA estimates it takes a medical examiner approximately eight minutes to complete the physical examination form and one minute to complete the medical examiner's certificate. The FMCSA estimates that approximately 18,300 drivers would be subject to the proposed rule. Since a medical examiner's certificate is usually made valid for 24 months, the prorated annual time burden would be approximately 1,375 hours per year [(0.15 hours per driver) × 18,300 drivers = 2,750 hours every two years × ½]. The FMCSA will submit the amended, proposed medical qualification information collection to the OMB for review and approval. Accordingly, the FMCSA seeks public comment on this

proposed information collection requirement.

Motor carriers that employ such CMV drivers would be required to maintain a complete driver qualification file for each driver in accordance with 49 CFR 391.51. The information collection requirements related to driver qualification files have been approved by the OMB under the provisions of the PRA and assigned the control number of 2126–0004 which is currently due to expire on January 31, 2001. The FMCSA estimates the creation of a single, complete driver qualification file involves an annual expenditure of approximately 24 minutes per year per driver employed (or 0.4 hours per year per driver employed) which is the sum of 20 minutes of paperwork by a safety director, driver supervisor, or equivalent position, and 4 minutes of paperwork by a driver. The 24 minutes does not include the time necessary to complete routine and customary tasks that are involved in hiring an employee. Based on the estimate of 18,300 drivers who would be subject to the proposed rule, the FMCSA estimates the total time burden to be 7,320 hours [(0.4 hours per year per driver employed) × (18,300 driver employed) = 7,320 hours per year]. The FMCSA will submit the amended, proposed medical qualification information collection to the OMB for review and approval. Accordingly, the FMCSA seeks public comment on this proposed information collection requirement.

Drivers of such CMVs would be required to record their duty status in accordance with 49 CFR 395.8. The information collection requirements related to records of duty status have been approved by the OMB under the provisions of the PRA and assigned the control number of 2126–0001 which expires October 31, 2001. The FMCSA estimates that it takes a CMV driver approximately two minutes for each workday to complete a record of duty status. Based on the estimate of 18,300 drivers who would be subject to the proposed rule and an average of five workdays per week for these drivers, the FMCSA estimates the total time burden to be 137,250 hours ((2 minutes per driver/day) × (1 hour/60 minutes) = 0.03 hours per day per driver; (0.03 hours per day per driver) × (5 days per week per driver) × (50 workweeks per year per driver) = 7.5 hours per driver; (7.5 hours per driver) × 18,300 drivers = 137,250 hours per year). The FMCSA will submit the amended, proposed driver qualification file information collection to the OMB for review and approval. Accordingly, the FMCSA seeks public comment on this proposed information collection requirement.

Motor carriers operating CMVs designed or used to transport between 9 and 15 passengers for direct compensation would be required to maintain records of inspection, repair, and maintenance for their CMVs in accordance with 49 CFR part 396. The information collection requirements related to inspection, repair, and maintenance have been approved by the OMB under the provisions of the PRA and assigned the control number of 2126–0003 which expired on January 31, 2001, and is in the process of being renewed. The FMCSA estimates that it would take a total annual expenditure of 12 hours and 57 minutes per year per CMV to complete the required recordkeeping related to vehicular inspection, repair, and maintenance (48 minutes per year per vehicle for systematic inspection, repair, and maintenance; 12 hours and 4 minutes per year per vehicle for driver vehicle inspection reports; and 5 minutes per year per vehicle for periodic inspection).

Evidence of an individual's qualifications to perform periodic vehicle inspections must be retained by the motor carrier. Evidence of an individual's qualifications to be a brake inspector must be retained also. The creation of these two types of qualification evidence involves an estimated one-time, non-recurring expenditure of 5 minutes by a safety director, driver supervisor, or equivalent position for each type of inspector. Based on an estimate of 1,650 motor carriers that would be subject to the proposed rule and on the assumption that each motor carrier has at least one employee who is a qualified periodic vehicle inspector and one employee who is a qualified brake inspector, the estimated total time burden related to the inspector qualifications rules is approximately 275 hours ((5 minutes for each periodic vehicle inspector certification × 1,650 motor carriers) + (5 minutes for each brake inspector certification × 1,650 motor carriers) = 16,500 minutes = 275 hours).

The FMCSA estimates that the total inspection, repair, and maintenance recordkeeping burden is approximately 213,675 hours per year ((16,500 CMVs) × (12.95 hours per year per CMV)) with an additional 275 hours in the first year for inspector qualifications. The FMCSA will submit the amended, proposed inspection, repair, and maintenance information collection to the OMB for review and approval.

The FMCSA seeks public comment on these proposed information collection requirements. Interested parties are invited to send comments regarding any aspect of these information collection requirements, including, but not limited to: (1) Whether the collection of information is necessary for the performance of the functions of the FMCSA, including whether the information has practical utility; (2) the accuracy of the estimated burdens; (3) ways to enhance the quality, utility, and clarity of the collection of information; and (4) ways to minimize the collection burden without reducing the quality of the information collected.

National Environmental Policy Act

The agency has analyzed this rulemaking for the purpose of the National Environmental Policy Act of 1969 (42 U.S.C. 4321 *et seq.*) and has determined that this action does not have any effect on the quality of the environment.

Unfunded Mandates Reform Act of 1995

This proposed rule does not impose an unfunded Federal mandate, as defined by the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532 *et seq.*), that will result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year.

Executive Order 12988 (Civil Justice Reform)

This action meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden.

Executive Order 13045 (Protection of Children)

The FMCSA has analyzed this action under Executive Order 13045, Protection of Children from Environmental Health Risks and Safety Risks. This proposed rule is not an economically significant rule and does not concern an environmental risk to health or safety that may disproportionately affect children.

Executive Order 12630 (Taking of Private Property)

This proposed rule will not effect a taking of private property or otherwise have taking implications under Executive Order 12630, Governmental Actions and Interference with Constitutionally Protected Property Rights.

Executive Order 13132 (Federalism Assessment)

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 13132, dated August 4, 1999, and it has been determined that this rulemaking does not have a substantial direct effect or sufficient federalism implications on States that would limit the policymaking discretion of the States. Nothing in this document directly preempts any State law or regulation. This proposed rule does not impose additional costs or burdens on the States.

Regulation Identification Number

A regulatory identification number (RIN) is assigned to each regulatory action listed in the Unified Agenda of Federal Regulations. The Regulatory Information Service Center publishes the Unified Agenda in April and October of each year. The RINs contained in the heading of this document can be used to cross reference this action with the Unified Agenda.

List of Subjects

49 CFR Part 385

Highway safety, Motor carriers.

49 CFR Part 390

Highway safety, Motor carriers, Motor vehicle identification and marking, Reporting and recordkeeping requirements.

49 CFR Part 398

Highway safety, Migrant labor, Motor carriers, Motor vehicle safety, Reporting and recordkeeping requirements.

Issued on: January 4, 2001.

Clyde J. Hart, Jr.,

Acting Deputy Administrator.

For the reasons set forth in the preamble, the FMCSA proposes to amend title 49, Code of Federal Regulations, parts 385, 390, and 398 as follows:

PART 385—[AMENDED]

1. The authority citation for part 385 continues to read as follows:

Authority: 49 U.S.C. 113, 504, 521(b)(5)(A) and (b)(8), 5113, 31136, 31144, 31502; and 49 CFR 1.73.

§ 385.1 [Amended]

2. Amend § 385.1 by revising paragraph (b) to read as follows:

* * * * *

(b) The provisions of this part apply to all motor carriers subject to the requirements of this subchapter, except non-business private motor carriers of passengers.

PART 390—[AMENDED]

3. Revise the authority citation for part 390 to read as follows:

Authority: 49 U.S.C. 13301, 13902, 31132, 31133, 31136, 31502, and 31504; sec. 204, Pub. L. 104–88, 109 Stat. 803, 941 (49 U.S.C. 701 note); sec. 212, Pub. L. 106–159, 113 Stat. 1748, 1766; and 49 CFR 1.73.

4. Amend § 390.3 by revising paragraph (f)(6) to read as follows:

§ 390.3 General applicability.

* * * * *

(f)(6)(i) The operation of commercial motor vehicles designed or used to transport between 9 and 15 passengers (including the driver) not for direct compensation, except that motor carriers operating such vehicles are required to comply with §§ 390.15, 390.19, and 390.21(a) and (b)(2).

(ii) The operation of commercial motor vehicles designed or used to transport between 9 and 15 passengers (including the driver) for direct compensation provided none of the passengers is being transported a distance greater than 75 air miles (86.3 statute miles or 138.9 kilometers), except that motor carriers operating such vehicles are required to comply with §§ 390.15, 390.19, and 390.21(a) and (b)(2).

* * * * *

5. Amend § 390.5 by adding a definition for ''direct compensation'' in alphabetical order to read as follows:

§ 390.5 Definitions.

* * * * *

Direct compensation means payment made to the motor carrier by the passengers or individual acting on behalf of the passengers for the transportation services provided, and not included in a total package charge or other assessment for highway transportation services.

* * * * *

PART 398—[AMENDED]

6. The authority citation for part 398 is revised to read as follows:

Authority: 49 U.S.C. 13301, 13902, 31132, 31133, 31136, 31502, and 31504; sec. 204, Pub. L. 104–88, 109 Stat. 803, 941 (49 U.S.C. 701 note); sec. 212, Pub. L. 106–159, 113 Stat. 1748, 1766; and 49 CFR 1.73.

7. Revise § 398.2 to read as follows:

§ 398.2 Applicability.

(a) *General.* The regulations prescribed in this part are applicable to carriers of migrant workers by motor vehicle, as defined in § 398.1(b), but only in the case of transportation of any migrant worker for a total distance of more than 75 miles (120.7 kilometers) in interstate commerce, as defined in 49 CFR 390.5.

(b) *Exception.* (1) The regulations prescribed in this part are not applicable to carriers of migrant workers by motor vehicle, as defined in § 398.1(b), when:

(i) The motor vehicle is designed or used to transport between 9 and 15 passengers (including the driver);

(ii) The motor carrier is directly compensated for the transportation service; and

(iii) Any migrant worker is transported a total distance of more than 75 air miles (86.3 statute miles or 138.9 kilometers).

(2) Carriers of migrant workers by motor vehicle operating vehicles, designed or used to transport between 9 and 15 passengers (including the driver), for direct compensation in interstate commerce must comply with the applicable requirements of 49 CFR parts 390, 391, 392, 393, 395, and 396 when a migrant worker is transported a total distance of more than 75 air miles (86.3 statute miles or 138.9 kilometers).

[FR Doc. 01–764 Filed 1–10–01; 8:45 am]

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Federal Register

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Part VIII

Department of Labor

Office of Labor-Management Standards

Interpretation of the "Advice" Exemption in Section 203(c) of the Labor-Management Reporting and Disclosure Act; Notice

DEPARTMENT OF LABOR

Office of Labor-Management Standards

Interpretation of the ''Advice'' Exemption in Section 203(c) of the Labor-Management Reporting and Disclosure Act

AGENCY: Office of Labor-Management Standards, Employment Standards Administration, Labor.

ACTION: Notice of revised statutory interpretation.

SUMMARY: The Department of Labor's Office of Labor-Management Standards (OLMS) intends to implement a revised interpretation, by the Secretary of Labor, of Section 203(c) of the Labor-Management Reporting and Disclosure Act (LMRDA). That statutory provision creates an ''advice'' exemption from reporting requirements that apply to employers and other persons in connection with persuading employees about the right to organize and bargain collectively. This notice announces a revised interpretation of LMRDA Section 203(c), as it applies to persuasive communications made to employees. The Department of Labor will, as a matter of enforcement policy, apply this revised interpretation prospectively, to conduct occurring 30 days or more after the date of this Notice.

FOR FURTHER INFORMATION CONTACT: Kay H. Oshel, Chief, Division of Interpretations and Standards, Office of Labor-Management Standards, Employment Standards Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Room N–5605, Washington, DC 20210. (202) 693–1233 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: The Secretary of Labor administers the Labor-Management Reporting and Disclosure Act of 1959, as amended (LMRDA), Public Law 86–257, 73 Stat. 519–546, codified at 29 U.S.C. 401–531. Section 203 of the LMRDA, 29 U.S.C. 433, requires employers and other persons to file certain reports with the Department of Labor in connection with persuading employees about the right to organize and bargain collectively. The statute also creates an exemption from these reporting requirements if the activity involved is ''giving or agreeing to give advice'' to an employer. This notice: (1) Describes the relevant reporting requirements of LMRDA Section 203(a) and section 203(b), as well as the ''advice'' exemption of section 203(c); (2) discusses the history of the Department of Labor's interpretation of the section 203(c) ''advice'' exemption, as it applies to persuasive communications made to employees; (3) explains why the Department has reviewed its prior interpretation; and (4) announces a revised interpretation of the ''advice'' exemption, which will be applied prospectively by the Department as a matter of enforcement policy.

Under the Administrative Procedure Act (APA), 5 U.S.C. 553, the Department is not required to engage in notice-and-comment rulemaking in order to adopt or modify a statutory interpretation. The Department does not intend to publish a new regulation interpreting or implementing LMRDA section 203(c) in the Code of Federal Regulations.

A. The Reporting Requirements of LMRDA Section 203(a) and Section 203(b); the ''Advice'' Exemption of Section 203(c)

Among the abuses that prompted Congress to enact the Labor-Management Reporting and Disclosure Act in 1959 was questionable conduct by some employers and their labor relations consultants, which interfered with the right of employees to organize labor unions and to bargain collectively under the National Labor Relations Act. See, e.g., Senate Report No. 86–187 at 7–8 (1959), reprinted in 1959 United States Code Congressional and Administrative News 2326–2328. Congress believed that certain consultant activities ''should be exposed to public view,'' since they are ''disruptive of harmonious labor relations and fall into a gray area,'' even if they are not illegal or unfair labor practices. *Id.*

As a result, Congress imposed reporting requirements on employers and other persons, in LMRDA section 203. Under LMRDA Section 208, the Secretary of Labor is authorized to issue, amend, and rescind rules and regulations prescribing the form and publication of required reports, as well as ''such other reasonable rules and regulations * * * as he may find necessary to prevent the circumvention or evasion of such reporting requirements.'' 29 U.S.C. 438. The Secretary is also authorized (section 210) to bring civil actions to enforce the LMRDA's reporting requirements. 29 U.S.C. 440. Willful violations of the reporting requirements, knowingly false statements made in a report, and knowing failures to disclose a material fact in a report are subject to criminal penalties. LMRDA section 209, 29 U.S.C. 439.

LMRDA section 203(a) requires employers annually to report to the Department of Labor:

> any agreement or arrangement with a labor relations consultant or other independent contractor or organization pursuant to which such person undertakes activities where an object thereof, directly or indirectly, is to persuade employees to exercise or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing * * *.

29 U.S.C. 433(a)(4).[1] ''[A]ny payment (including reimbursed expenses) pursuant to an agreement or arrangement described in'' this provision must also be reported. 29 U.S.C. 433(a)(5).

The report must be one ''showing in detail the date and amount of each such payment, * * * agreement, or arrangement * * * and a full explanation of the circumstances of all such payments, including the terms of any agreement or understanding pursuant to which they were made.'' 29 U.S.C. 433. The Department of Labor's implementing regulations require employers to file a Form LM–10 (''Employer Report'') that contains this information in a prescribed form. 29 CFR part 405.

LMRDA section 203(b), in turn, imposes a similar reporting requirement on labor relations consultants and other persons. It provides, in part, that:

> Every person who pursuant to any agreement or arrangement with an employer undertakes activities where an object thereof is, directly or indirectly—(1) to persuade employees to exercise or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing * * * shall file within thirty days after entering into such agreement or arrangement a report with the Secretary * * * containing * * * a detailed statement of the terms and conditions of such agreement or arrangement.

29 U.S.C. 433(b). Section 203(b) also requires persons subject to this requirement to report their relevant receipts and disbursements. The Department of Labor's implementing regulations require labor relations consultants and other persons to file a Form LM–20 ''Agreement and Activities Report'' and a Form LM–21 ''Receipts and Disbursements Report'' that contain the required information in a prescribed form. 29 CFR part 406. Consistent with the Department's traditional

[1] The LMRDA defines a ''labor relations consultant'' as ''any person who, for compensation, advises or represents an employer, employer organization, or labor organization concerning employee organizing, concerted activites, or collective bargaining activities.'' 29 U.S.C. 402(m).

interpretation of LMRDA Section 203(b), Form LM–21 requires a consultant or other person who undertakes persuader activity for, or who supplies information to, one employer to report information related to ''labor relations advice or services'' that were provided to other employers. ''Labor relations advice or services'' refers to advice or services concerning employee organizing, representation, or concerted activities; collective bargaining activities; or labor disputes.

In addition to requiring reports from employers and other persons involved in ''persuasive activities,'' LMRDA section 203 also creates an exemption from these requirements for ''advisory or representative services.'' Section 203(c) provides in part that:

> Nothing in this section shall be construed to require any employer or other person to file a report covering the services of such person *by reason of his giving or agreeing to give advice to such employer.* * * *

29 U.S.C. 433(c) (italics added).

Finally, LMRDA section 204 creates an exemption from reporting for ''attorney-client communications,'' that is, ''information which was lawfully communicated to [an] * * * attorney by any of his clients in the course of a legitimate attorney-client relationship.'' 29 U.S.C. 434.

This Notice addresses the applicability of the LMRDA's reporting requirements when an employer enters into an agreement or arrangement with another person to produce *persuasive communications:* material such as speeches, scripts, documents, or videotapes that, in the words of LMRDA section 203(a) and section 203(b), are designed ''to persuade employees to exercise, or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing.'' The issue is whether, and under what circumstances, the activities of these persons constitute ''advice'' within the meaning of section 203(c) and thus need not be reported. Examples of persuasive communications would include (but would not be limited to) materials explicitly or implicitly urging employees to vote against union representation, to take a certain position with respect to collective bargaining proposals, or to refrain from concerted activity, such as a strike, in the workplace.

B. History of the Department of Labor's Interpretation of the ''Advice'' Exemption in LMRDA Section 203(c); the Most Recent Interpretation

The ''advice'' exemption of LMRDA section 203(c) is reflected in the Department's implementing regulations, but the regulations simply track the language of the statute. 29 CFR 405.6(b), 406.5(b). The Department has, however, interpreted the ''advice'' exemption in the course of administering the LMRDA. As explained below, this interpretation has varied in the years since the LMRDA was enacted.[2] Apparently, the Department has never provided public notice and opportunity for comment in connection with adopting or revising its interpretation of section 203(c). The Department's interpretation has been communicated primarily in documents intended to guide Department staff in administering the LMRDA and in documents distributed to the public to assist employers, labor relations consultants, and others in complying with the LMRDA.

1. The Department's Initial Interpretation of the ''Advice'' Exemption

In its earliest approach to the ''advice'' exemption, reflected in a 1960 publication to guide employers, the Department took the position that employers were required to report any ''arrangement with a ' labor relations consultant' or other third party to draft speeches or written material to be delivered or disseminated to employees for the purpose of persuading such employees as to their right to organize and bargain collectively.'' Department of Labor, Bureau of Labor-Management Reports, Technical Assistance Aid No. 4: Guide for Employer Reporting at p. 18 (1960).

The Department also took the position, in at least some opinion-letters to members of the public, that a lawyer or consultant's revision of a document prepared by an employer was reportable activity. In a 1961 article, a Department of Labor official, after noting that the drafting of speeches or written material by a consultant or lawyer was reportable, addressed the issue of revisions to material prepared by the employer:

> [A]dvice to a client with respect to a speech or letter, drafted by the client, is not reportable. However, if the individual undertakes to revise that speech, this constitutes an affirmative act; it is the undertaking of activities to persuade employees in the exercise of their rights and, comparable to the giving of a speech, requires reporting. *The Bureau [Bureau of Labor-Management Reports] takes the position that reporting is required in any situation where it is impossible to separate advice from activity which goes beyond advice.* In any situation where an attorney undertakes activities which are more than mere advice for the same employer, the exclusion of [LMRDA] section 203(c) does not apply since the causal relationship is clear.

Benjamin Naumoff, Reporting Requirements under the Labor-Management Reporting and Disclosure Act, in Fourteenth Annual Proceedings of the New York University Conference on Labor 129, 140–141 (1961) (italics added).

2. The Department's Most Recent Interpretation of the ''Advice'' Exemption

In 1962, the Department changed its original view of the ''advice'' exemption, adopting what remained the Department's interpretation until now.

The change is reflected in a February 19, 1962 memorandum from then Solicitor of Labor Charles Donahue to John L. Holcombe, then Commissioner of the Bureau of Labor-Management Reports, in response to a November 17, 1961 memorandum from Commissioner Holcombe. Commissioner Holcombe's memorandum sought guidance from Solicitor Donahue on ''exactly what the Department's position is with respect to the drafting and editing of communications to employees which are intended to persuade employees.'' Holcombe endorsed the view that the initial preparation of a persuasive document by a lawyer or consultant for use by an employer was reportable, but that revising a draft constituted ''advice'' for purposes of Section 203(c).

In response, the Donahue memorandum addressed three situations: (1) Where persuasive material is prepared and delivered by the lawyer or consultant; (2) where an employer drafts the material and intends to deliver it to his employees, and a lawyer or other person provides oral or written advice on its legality; and (3) where a lawyer or consultant prepares an entire speech or document for the employer.

The Donahue memorandum concluded that the first activity (preparation and delivery of material) was reportable; that the second activity (legal review of a draft) constituted

[2] That the ''advice'' exemption of LMRDA Section 203(c) might pose interpretive challenges was quickly clear to at least some observers. *See, e.g.,* Bureau of National Affairs, The Labor Reform Law 36 (1959) (''The exemption applicable to consultants who merely give advice is susceptible of several different interpretations. * * * It is questionable whether the exemption would also cover payments to a consultant who drafted anti-union letters and otherwise mapped out a campaign to combat union organizing'').

''advice;'' and that the third activity (preparation of an entire document) ''can reasonably be regarded as a form of written advice where it is carried out as part of a bona fide undertaking which contemplates the furnishing of advice to an employer.'' In discussing the preparation of an entire document, the Donahue memorandum observed:

> [S]uch activity in itself will not ordinarily require reporting unless there is some indication that the underlying motive is not to advise the employer. In a situation where the employer is free to accept or reject the written material prepared for him and there is no indication that the middleman is operating under a deceptive arrangement with the employer, that fact that the middleman drafts the material in its entirety will not in itself generally be sufficient to require a report.

The Donahue memorandum did not explicitly analyze the language of LMRDA section 203 or the statute's legislative history, but asserted that both had been examined.

In a 1962 presentation to the American Bar Association's Section of Labor Relations Law, Solicitor Donahue described the Department's original interpretation of the ''advice'' exemption this way:

> [T]he Department of Labor originally took the position that [the exemptions in LMRDA section 203(b) and section 204] did not extend to drafting or revising speeches, statements, notices, letters, or other materials by attorneys or consultants for the use of dissemination by employers to employees for the purpose of persuading them with respect to their organizing or bargaining rights. This kind of help was not viewed as advice but, instead, was regarded as an affirmative act with the direct or indirect objective of persuading employees in the exercise of their rights.

Charles Donahue, Some Problems under Landrum Griffin in American Bar Association, Section of Labor Relations Law, Proceedings 48–49 (1962). Donahue observed that this position had been ''reviewed in the light of Congressional intent,'' which revealed ''no apparent attempt to curb labor relations advice in whatever setting it might be couched.'' Id. at 49. Expert legal advice was often necessary, Donahue suggested, and thus:

> Even where this advice is embedded in a speech or statement prepared by the advisor to persuade, it is nevertheless advice and must be fairly treated as advice. The employer and not the advisor is the persuader.

Id.

The conclusions and language of the 1962 Donahue memorandum appear in section 265.005 (''Scope of the Advice Exemption'') of the LMRDA Interpretative Manual. The Manual reflects the Department's official interpretations of the LMRDA and is designed to guide the work of the staff of the Office of Labor-Management Standards in the administration and enforcement of the statute. Section 265.005 of the Manual states:

> Section 203(b) provides for reports from every person who pursuant to an agreement or arrangement with an employer undertakes the type of activities described therein. Section 203(c) provides that nothing in section 203 shall be construed to require any person to file a report * * * by reason of his giving or agreeing to give advice to such employer * * *.''
>
> The question of application of the ''advice'' exemption requires an examination of the intrinsic nature and purpose of the arrangement to ascertain whether it essentially calls exclusively for advice or other services in whole or in part. Such a test cannot be mechanically or perfunctorily applied. It involves a careful scrutiny of the basic fundamental characteristics of any arrangement to determine whether giving advice or furnishing some other services is the real underlying motivation for it.
>
> As to specific kinds of activity, it is plain that the preparation of written material by a lawyer, consultant, or other independent contractor which he directly delivers or disseminates to employees for the purpose of persuading them with respect to their organizational or bargaining rights is reportable. Moreover, the fact that such material may be delivered or disseminated through an agent would not alter the result. Such undertakings obviously do not call for the giving of advice to an employer.
>
> However, it is equally plain that where an employer drafts a speech, letter or document which he intends to deliver or disseminate to his employees for the purpose of persuading them in the exercise of their rights, and asks a lawyer or other person for advice concerning its legality, the giving of such advice, whether in written or oral form, is not in itself sufficient to require a report. Furthermore, we are now of the opinion that the revision of the material by the lawyer or other person is a form of written advice given the employer which would not necessitate a report.
>
> A more difficult problem is presented where the lawyer or middleman prepares an entire speech or document for the employer. We have concluded that such an activity can reasonably be regarded as a form of written advice where it is carried out as part of a bona fide undertaking which contemplates the furnishing of advice to an employer. Consequently, such activity in itself will not ordinarily require reporting unless there is some indication that the underlying motive is not to advise the employer. In a situation where the employer is free to accept or reject the written material prepared for him and there is no indication that the middleman is operating under a deceptive arrangement with the employer, the fact that the middleman drafts the material in its entirety will not in itself generally be sufficient to require a report.

In later years, the Department reiterated the 1962 position, sometime expressing doubts about its soundness. See Oversight Hearings on Landrum-Griffin Act before the Subcommittee on Labor-Management Relations of the House of Representatives Committee on Education and Labor 98th Cong. 342 (1984) (statement of Richard Hunsucker, Director, Office of Labor-Management Standards Enforcement, Labor-Management Standards Administration, U.S. Department of Labor); 4 Pressures in Today's Workplace: Oversight Hearing before the Subcommittee on Labor-Management Relations of the House of Representatives Committee on Education and Labor, 96th Cong. 5 (1980) (statement of William Hobgood, Assistant Secretary of Labor for Labor-Management Relations) (current interpretation ''when stretched to its extreme, * * * permits a consultant to prepare and orchestrate the dissemination of an entire package of persuader material while sidestepping the reporting requirement merely by using the employer's name and letterhead or avoiding direct contact with employees'').

3. The Kawasaki Motor Corporation Litigation: International Union, United Automobile Workers v. Dole

The Department of Labor's most recent public statements involving the ''advice'' exemption were made in the context of litigation. The Department's position in the litigation was consistent with, and derived from, the interpretation of LMRDA section 203(c) reflected in the Donahue memorandum and the LMRDA Interpretative Manual.

In 1982, the United Automobile Workers sued the Department, seeking to compel the Department to proceed against the Kawasaki Motor Corporation for failing to report conduct that allegedly was reportable under LMRDA section 203(a) and 203(b). One focus of the litigation was Kawasaki's payments to a consultant to devise personnel policies to discourage unionization. The Department took the position that the payments were not reportable, since the consultant's activity constituted ''advice'' under section 203(c). In a statement of its reasons for not proceeding against Kawasaki, the Department cited section 265.005 of the LMRDA Interpretative Manual and stated: ''An activity is characterized as advice if it is submitted orally or in written form to the employer for his use, and the employer is free to accept or reject the oral or written material submitted to him.''

A federal district court ruled against the Department. *International Union* v.

Secretary of Labor, 678 F. Supp. 4 (D.D.C. 1988). However, the U.S. Court of Appeals for the District of Columbia Circuit reversed this ruling and deferred to the Department's interpretation of LMRDA section 203 as reasonable in the context of the case, since the statute itself was ''silent or ambiguous with respect to the issues before'' the court. *International Union, United Automobile Workers* v. *Dole,* 869 F.2d 616, 617 (D.C. Cir. 1989).

Following the decision of the Court of Appeals, OLMS staff has been guided by a March 24, 1989 memorandum from then Acting Deputy Assistant Secretary for Labor-Management Standards Mario A. Lauro, Jr. The Lauro Memorandum cited LMRDA Interpretative Manual Section 265.005 and stated:

> [T]here is no purely mechanical test for determining whether an employer-consultant agreement is exempt from reporting under the Section 203(c) advice exemption. However, a usual indication that an employer-consultant agreement is exempt is the fact that the consultant has no direct contact with employees and limits his activity to providing to the employer or his supervisors advice or materials for use in persuading employees which the employer has the right to accept or reject.

C. Reasons for Revising the Department's Interpretation of the ''Advice'' Exemption in LMRDA Section 203(c)

The Department has decided to revise its most recent interpretation of the ''advice'' exemption (as adopted in 1962 and reflected in the LMRDA Interpretative Manual and later statements derived from the Manual), in favor of an interpretation that best captures the intent of Congress in enacting the LMRDA and that today best achieves the aims of the statute. There is persuasive evidence that the most recent interpretation has led to the under-reporting of activities that Congress believed should be disclosed to employees and to the public, particularly given the apparent growth in the use of labor relations consultants beginning in the 1970's. The revised interpretation, discussed below, is superior to the prior interpretation in these respects. The LMRDA is silent or ambiguous on the issues addressed here. See *International Union, United Automobile Workers* v. *Dole,* 869 F.2d 616 (D.C. Cir. 1989) (discussed above). As a result, the Department is free to reconsider its prior interpretation and to adopt a different interpretation, so long as it, too, is reasonable. See, *e.g., Rust* v. *Sullivan,* 500 U.S. 173 (1991); *Chevron, U.S.A., Inc.* v. *Natural Resources Defense Council, Inc.,* 467 U.S. 837 (1984).

1. The Textual Basis for the Prior Interpretation Is Dubious

As explained, under the Department's most recent interpretation of LMRDA Section 203(c), the preparation of an entire speech or document for an employer is considered ''a form of written advice where it is carried out as part of a bona fide undertaking which contemplates the furnishing of advice to an employer.'' LMRDA Interpretative Manual, section 265.005. This interpretation is in tension with the ordinary meaning of the term ''advice,'' used in Section 203(c).

''Advice'' is ordinarily understood to mean a recommendation regarding a decision or a course of conduct. See, e.g. Webster's Third New International Dictionary of the English Language Unabridged 32 (1968) (defining ''advice'' as ''recommendation regarding a decision or course of conduct: counsel''); Black's Law Dictionary 55 (defining ''advice'' as ''guidance offered by one person, esp. a lawyer, to another'') (7th ed. 1999); 1 The Oxford English Dictionary 191 (defining ''advice'' as ''opinion given or offered as to action; counsel. *spec.* medical or legal counsel'') (2d ed. 1989). This understanding of ''advice'' seems easily to cover situations where an employer has drafted persuasive material, which a lawyer or consultant reviews at the employer's request to determine whether the statements in the material are allowed by the National Labor Relations Act. But a consultant or lawyer's own preparation of material that will be distributed or disseminated to employees is an activity that seems different in kind from reviewing or editing the employer's work-product. The most recent interpretation, however, treats these two activities the same way: neither must be reported.

While a consultant or lawyer may recommend that the employer use the persuasive material that he has prepared, the preparation of the material is not itself a recommendation and thus not ''advice'' in the ordinary sense. For example, to the extent that the persuasive material is disseminated to employees, it is clearly not the sort of communication that would be protected from disclosure by the attorney-client privilege: the material itself has been deliberately disclosed to third parties and any privilege has thus been waived. The Department's most recent view-that preparation of material is advice, so long as the employer is free to accept or reject the material—is open to question. Because an employer generally has the authority to accept or reject the work done for him (and can exercise that authority whenever he is aware of the work), the scope of the ''advice'' exemption as most recently applied is very broad.

For purposes of the LMRDA, the distinction between direct communication by a consultant or a lawyer, and situations where an employer essentially serves as the channel for a communication by a consultant or a lawyer, is not clear. The important role of a person other than the employer in persuading employees would seem to be what Congress intended to be disclosed to employees and to the public, since Congress believed that there is a potential for abuse when employers rely heavily on third parties in the context of union organizing drives and collective bargaining. See, e.g., Senate Report No. 86–187 at 7–8 (1959), reprinted in 1959 United States Code Congressional and Administrative News 2327 (citing evidence ''showing that large sums of money are spent in organized campaigns on behalf of some employers' and stating that such activities ''should be exposed to public view'').

The Department's most recent approach seems inconsistent with LMRDA section 203(a)(4), which refers to ''activities where an object thereof, directly or indirectly, is to persuade employees,'' and with LMRDA section 203(b), which uses a nearly identical formulation (''activities where an object thereof is, directly or indirectly—to persuade employees''). The direct object, or at least the indirect object, of preparing persuasive material that is intended to be transmitted to employees is to persuade employees. It seems reasonable to believe that Congress envisioned that this type of activity, which goes beyond just giving advice in the ordinary sense, would be reported. In discussing the provision that became Section 203(c), for example, a Senate committee report observed that, ''An attorney or consultant who confines himself to giving legal advice * * * would not be included among those required to file reports. * * *'' Senate Report No. 86–187 at 7–8 (1959), reprinted in 1959 United States Code Congressional and Administrative News 2328. It seems fair to infer that reporting is required when a person engages in activities that involve persuasion in addition to giving advice. In such instances, the lawyer or consultant functions less as an advisor to the employer than as a persuader of employees.

2. The Most Recent Interpretation Has Harmed the Effectiveness of the LMRDA in Requiring Disclosure of Persuader Activities

The objections to the Department's most recent interpretation of LMRDA section 203(c) as a matter of statutory construction are not the only basis for reviewing that interpretation. The apparent practical consequences of the interpretation also suggest the need for revision.

Over the years, the Department's most recent interpretation of the ''advice'' exemption has been criticized by a Congressional subcommittee and by commentators, who have suggested that the interpretation has seriously harmed the effectiveness of the LMRDA in requiring the disclosure of persuader activities.[3]

More recently, a former labor relations consultant, Martin Jay Levitt, has published a book that seems to confirm this criticism. Discussing the LMRDA (also known as the Landrum-Griffin Act, after its Congressional sponsors), Mr. Levitt has written:

> The law states that management consultants only have to file financial disclosures if they engage in certain kinds of activities, essentially attempting to persuade employees not to join a union or supplying the employer with information regarding the activities of employees or a union in connection with a labor relations matter. Of course, that is precisely what anti-union consultants do, have always done. Yet I never filed with Landrum-Griffin in my life, and few union busters do. Here's why not: *According to the law, in order to be engaged in ''persuader'' activities, the consultant must speak directly to the employees in the voting unit.* As long as he deals directly only with supervisors and management, he can easily slide out from under the scrutiny of the Department of Labor, which collects the Landrum-Griffin reports.
>
> Martin Jay Levitt (with Terry Conrow), Confessions of a Union Buster 41–42 (New York: Crown Publishers, Inc. 1993) (italics added). Mr. Levitt's description of the actual practice of labor relations consultants is consistent with prior statements by other consultants. See Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 96th Cong., Pressures in Today's Workplace 44 (Comm. Print 1980) (quoting testimony of labor relations consultant and stating that the ''current interpretation of the law has enabled employers and consultants to shield their arrangements and activities'').

Considering Mr. Levitt's apparent personal experience in the field, his statement raises concerns about the effectiveness of the LMRDA's reporting provisions, in light of the Department's most recent interpretation of the ''advice'' exemption. Mr. Levitt's statement is incorrect in suggesting that the LMRDA, by its terms, requires direct contact between a consultant and employees before the statutory duty to report persuader activities is triggered. But the Department's most recent interpretation of LMRDA section 203(c) lends itself to the understanding described by Mr. Levitt, since it views most activity other than direct contact between a consultant and employees as falling within the ''advice'' exemption. If Mr. Levitt's statement is accurate, then the Department's most recent interpretation may be contributing to the substantial under-reporting of persuader activities that Congress wanted disclosed.

Since 1962, when the Department's most recent interpretation of the ''advice'' exemption was adopted, the means and methods used by labor relations consultants to market themselves to employers and to persuade workers have become more sophisticated, reflecting new technologies.

For example, one prominent labor relations consulting firm—which recently merged with another, long-established firm—advertises its services on the Internet. Its Website announced that the ''new firm will have combined billings of $5.5 million,'' that it ''represents the merger of the field's top intellectual assets in response to the explosive growth of union organizing across the country,'' and that the two merging firms ''have worked with thousands of companies over the years.'' Among the services offered by the firm on its Website are ''full scale counter-union campaigns.'' The firm states, ''We know how unions organize employees, why employees turn to unions, and how to keep unions out. * * *'' Among the products offered by the firm is a videotape called ''Inside the Union.'' The firm describes it this way:

> [The firm] can produce a customized video for your organization that goes inside the union that is attempting to organize your employees * * * This tape provides your employees with everything they need to make an informed decision at the voting booth.

The firm invites employers to ''discuss how Inside the Union can fit into your counter-union campaign.''

The use of consultant-prepared, customized video presentations appears to be a common persuasive technique. One consultant firm, on its Website, describes its ''custom video presentations for management,'' begun in 1984, which evolved into an ''NLRB Representation Election Campaign Program,'' ''used in more than 3,000 elections.'' According to the firm, ''[t]his revolutionary approach utilized a series of captive audience videos that enabled employers to effectively conduct their own campaigns without expensive consulting services.'' The firm describes its videos as ''credible communications that inform and persuade employees,'' noting that its ''standards * * * mean that [the employer's] union-free message commands attention and respect.''

Other firms offer services that depend less on high technology. The Website of one firm offers services that include ''developing flyers aimed [at] company specific issues.'' According to the firm ''flyers mailed to worker's homes let family members realize what is at stake.'' In the words of another firm's Website, addressed to employers, it can help ''get your anti-union message indelibly engraved upon your employee's minds.''

The sophistication of today's labor relations consultants is apparent from their Internet sites, like those just described. Many consultants have such sites, which they use to market their services in a way that was not possible in 1962. The Internet sites seemingly illustrate the important role consultants play in employers' responses to union organizing campaigns. One firm describes itself as ''providing professional on-site campaign management expertise'' and says it has been involved in 930 campaigns. Its services include ''persuader, bilingual, and custom video campaigns,'' billed as ''highly credible, direct employee communications that build lasting positive impressions.'' The firm refers to its staff members as ''professional campaign managers,'' who are ''thoroughly experienced in developing and using video, internet, and multi-media based communications programs.'' Staff members ''design a winning strategy and deliberate tactics fine-tuned to the particular issues and requirements of your [the employer's] campaign.''

Like the firms already described, other labor relations consultants who

[3] *See* Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 98th Cong., The Forgotten Law—Disclosure of Consultant and Employer Activity under the LMRDA 13–14 (Comm. Print 1984); Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 96th Cong., Pressures in Today's Workplace 43–44 (Comm. Print 1980); Jules Bernstein, Union-Busting: From Benign Neglect to Malignant Growth, 14 U.C. Davis L. Rev. 1, 23–27 (1980).

advertise on the Internet make clear that they provide comprehensive services to employers. One firm, which has claimed involvement in 950 union representation and decertification elections over 25 years, offers ''campaigns to defeat Union attempts to organize employees.'' Another firm's Website offers ''counter-union organizing strategies'' and ''union avoidance'' efforts, among services ''custom designed to meet the needs of the individual client.'' The firm observes, ''When organizing occurs, [the firm] works closely with the employer's management team to ensure that employees receive full and accurate information regarding what a union can and cannot do for them.'' A different firm offers ''union avoidance campaigns'' among its services, describes itself as ''nationally recognized as a leader in conducting successful campaigns for companies,'' and points out that it can ''strategically utilize the expertise and skills of company supervisors to influence a positive outcome to elections.''

In addition to consulting firms, law firms also appear to be engaged in developing persuasive communications, as well as more traditional legal work. One law firm Website, in describing its ''legal services to management,'' includes (in addition to ''advice and counsel'') ''union avoidance,'' noting that its ''lawyers are prepared to counter the union's efforts with election campaign tactics,'' ''focusing on not only why employees should vote against the union, but why they should vote for the kind of relationship they really want to have with their employer.'' Similarly, another law firm says that it ''frequently advises clients in union avoidance, organizing campaigns, and representation elections' and ''frequently assist[s] * * * clients in employee communication strategies, including the development of speeches, multimedia, and written employee communications.''

Evidence suggests since the 1960's, the use of labor relations consultants by employers has increased significantly, that such consultants play an important role in connection with the process of union organizing efforts, and that this role may contribute to harmful conflicts in American workplaces. Reporting by labor relations consultants under the Department's most recent interpretation of LMRDA section 203(c) does not appear fully to reflect the scale and scope of consultant activity.

Observers of American labor relations have noted an increased use of labor relations consultants in the years since the Department's most recent interpretation of the ''advice'' exemption was adopted. See, *e.g.,* Unions and Management Representatives Disagree on Extent of Consultants' Influence in 75 Daily Labor Report (Bureau of National Affairs) at C–1 (April 19, 1988) (''The number of labor relations consultants * * * has proliferated in recent years''). A 1984 Congressional subcommittee report observed:

> In the 25 years since the enactment of the LMRDA there has been a dramatic increase in management's use of consultants to counter the unionization efforts of employees or to decertify existing unions. This well-documented increase has been most pronounced in the past 10 years.

Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 98th Cong., The Forgotten Law—Disclosure of Consultant and Employer Activity under the LMRDA 2 (Comm. Print 1984).[4] See also Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 96th Cong., Pressures in Today's Workplace 28 (Comm. Print 1980) (''[T]he labor consultant industry has undergone very substantial growth since the Landrum-Griffin Act [LMRDA], particularly during the past decade.''). A scholar has described the apparent trend this way:

> Anti-union labor relations consultants became fairly active in the 1950s; they were important enough to be the subject of congressional investigations in 1958 and 1959. By the 1970s, however, they came to represent a quantitatively and qualitatively different phenomenon. From being atypical in the late 1950s, they became the usual occurrence in the 1970s; their activities continue unabated today.

Michael Goldfield, The Decline of Organized Labor in the United States 193 (Chicago: University of Chicago Press, 1987). For a similar description of this trend, see Michael H. LeRoy, *Severance of Bargaining Relationships During Permanent Replacement Strikes and Union Decertifications: An Empirical Analysis and Proposal to Amend Section 9(c) of the NLRA*, 29 U.C. Davis L. Rev. 1019, 1072–1077 (1996).

In its 1994 fact-finding report, an advisory committee appointed by the Secretary of Labor and the Secretary of Commerce and chaired by Professor John T. Dunlop of Harvard University, found that ''[f]irms spend considerable internal resources and often hire management consulting firms to defeat unions in organizing campaigns at a sizable cost.'' Commission on the Future of Worker-Management Relations (Dunlop Commission), Fact Finding Report at p. 74 (May 1994). The same report observed that ''[s]tudies show that consultants are involved in approximately 70 percent of organizing campaigns,'' but also stated that ''[t]here are no accurate statistics on consultant activity.'' Id. at p. 68.[5]

Some studies of employers' use of labor relations consultants have been done. They suggest that employers frequently use consultants. A study based on a random sample of 261 National Labor Relations Board elections between July 1986 and July 1987, found that 71 per cent of employers used an outside consultant during the election campaign. Kate L. Bronfenbrenner, Employer Behavior in Certification Elections and First-Contract Campaigns: Implications for Labor Law Reform in Restoring the Promise of American Labor Law 80 (Sheldon Friedman et al. eds., 1994) (Ithaca, N.Y.: ILR Press). The use of consultants, according to the study, appears to have an effect on the outcome of union representation elections: unions won 40 per cent of the elections in which employers used a consultant, as opposed to 50 per cent when no consultant was used. Regardless of the effect, the common use of consultants in the course of union election campaigns suggests widespread persuader activity that may be subject to the LMRDA's reporting requirements.

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[4] Witnesses at Congressional subcommittee hearings in 1979 and 1980, including both labor union officials and labor relations consultants, testified to a ''staggering increase in the number of practicing labor relations consultants.'' Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 96th Cong., Pressures in Today's Workplace 27 (Comm. Print 1980). One prominent consultant estimated ''tenfold growth in the past 10 years,'' *i.e.,* during the 1970's. Id. See 3 Pressures in Today's Workplace: Oversight Hearing before the Subcommittee on Labor-Management Relations of the House of Representatives Committee on Education and Labor, 96th Cong. 12 (1980) (testimony of Herbert G. Melnick, Modern Management, Inc.).

[5] In the past, a Congressional subcommittee has suggested that a ''careful study by the Department of Labor of the dimension and impact of this phenomenon [the growth in the number of labor relations consultants] is overdue.'' Subcommittee on Labor-Management Relations, Committee on Education and Labor, U.S. House of Representatives, 96th Cong., Pressures in Today's Workplace 28 (Comm. Print 1980). For a detailed analysis of the business of labor relations consultants in the mid-1980's, see Bureau of National Affairs, Labor Relations Consultants: Issues, Trends, and Controversies (1985). That report observed that ''[m]anagement consulting is a large industry'' and that ''[m]any observers see the industry growing.'' Id. at 3. But the report also pointed out that ''[b]ecause much of the management consultants'' work is done behind the scenes, keeping tabs on the activities of consultants—and thus getting an estimate of the size of the industry—is difficult.'' Id. at 5.

The reports of the Dunlop Commission, meanwhile, suggest that the use of labor relations consultants may be harmful to good labor-management relations.[6] In its fact-finding report, the Dunlop Commission observed that:

> The NLRA [National Labor Relations Act] process of representation elections is often highly confrontational with conflictual activity for workers, unions, and firms that thereby colors labor-management relations.

Commission on the Future of Worker-Management Relations, Fact Finding Report at p. 68 (May 1994). In its final report, the Commission noted the harm to good labor-management relations caused by the ''import of the worst features of political campaigns into the workplaces by managers and unions.'' Commission on the Future of Worker-Management Relations, Report and Recommendations at p. 15 (December 1994).

The apparent rise in the use of labor relations consultants since 1962, the reasonable possibility that some labor relations consultants contribute to harmful conflicts in labor-management relations (an object of Congressional concern in passing the LMRDA), and evidence that the Department's most recent interpretation of the ''advice'' exemption has led to the under-reporting of the activities of these consultants, all support revision of the interpretation.

[6] Labor relations consultants may be held liable by the National Labor Relations Board for unfair labor practices committed on behalf of employers. See, e.g., *Blankenship and Associates, Inc.* v. *N.L.R.B.,* 999 F.2d 248 (7th Cir. 1993), enforcing 306 N.L.R.B. 994 (1992). Employers may also be held liable, based on the actions of their consultants. See, e.g., Wire Products Manufacturing Corp., 326 N.L.R.B. No. 62 (1998).

D. Revised Interpretation of the ''Advice'' Exemption

For the reasons just described, the Department has revised its interpretation of LMRDA section 203(c) with respect to the preparation of persuasive materials by labor relations consultants and other persons. The Department's new interpretation, as it will appear in the LMRDA Interpretative Manual distributed to the staff of the Office of Labor-Management Standards (superseding section 265.005 of the most recent version of the Manual, described above), is as follows:

> LMRDA Section 203(b) requires reports from: ''every person who pursuant to any agreement or arrangement with an employer undertakes activities where an object thereof is, directly or indirectly—to persuade employees to exercise or not to exercise, or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing* * * .'' Section 203(c) provides that a person need not file a report ''by reason of giving or agreeing to give advice to * * * an employer.''
>
> The application of the ''advice'' exemption depends on whether an activity can fairly be considered giving ''advice,'' as opposed to engaging in direct or indirect persuasion of employees. ''Advice'' means an oral or written recommendation regarding a decision or a course of conduct.
>
> For example, a lawyer or consultant who counsels an employer on what he may lawfully say to employees or on how to exercise his legal rights most effectively is providing ''advice,'' even if the employer's communication is intended to persuade employees within the meaning of the LMRDA. This activity is not reportable.
>
> However, persons who give advice to employers may also engage in activities that must be reported. When a consultant or lawyer or their agent communicates directly with employees in an effort to persuade them, the ''advice'' exemption does not apply. The duty to report can be triggered even without direct contact between a consultant or lawyer and employees, if persuading employees is an object (direct or indirect) of the person's activity pursuant to an agreement or arrangement with an employer.
>
> For example, when such a person prepares or provides a persuasive script, letter, videotape, or other material for use by an employer in communicating with employees, no exemption applies and the duty to report is triggered.
>
> Material is persuasive if, for example, it explicitly or implicitly urges employees to vote against union representation, to take a certain position with respect to collective bargaining proposals, or to refrain from concerted activity (such as a strike) in the workplace.
>
> A lawyer or consultant who, as a means of providing legal or other advice, simply reviews and revises persuasive material prepared by the employer is not required to report that activity.

The Department will, as a matter of enforcement policy, apply this interpretation prospectively, to conduct occurring thirty days or more after the date of this Notice.

Signed at Washington, D.C., this 8th day of January, 2001.

Bernard E. Anderson,

Assistant Secretary for Employment Standards.

[FR Doc. 01–969 Filed 1–10–01; 8:45 am]

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Federal Register

Thursday,
January 11, 2001

Part IX

Office of Personnel Management

5 CFR Part 537
Repayment of Student Loans; Final Rule

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 537

RIN: 3206–AJ12

Repayment of Student Loans

AGENCY: Office of Personnel Management.

ACTION: Final rulemaking.

SUMMARY: The Office of Personnel Management (OPM) is issuing final regulations to implement provisions authorizing Federal agencies to repay federally insured student loans when necessary to recruit or retain highly qualified professional, technical, or administrative personnel.

DATES: Effective February 12, 2001.

FOR FURTHER INFORMATION CONTACT: Michael J. Mahoney, (202) 606–0830 (FAX 202–606–0390).

SUPPLEMENTARY INFORMATION: On June 22, 2000, OPM published proposed regulations to implement provisions of 5 U.S.C. 5379 (Public Law 101–510). Public Law 101–510 (National Defense Authorization Act for Fiscal Year 1991), section 1206, amends subchapter VII of 5 U.S.C. chapter 53, by adding a new section 5379. This section authorizes agencies to establish a program under which they may agree to repay all or part of an outstanding federally insured student loan to facilitate the recruitment or retention of highly qualified professional, technical, or administrative employees.

The repayment authority is one of several flexibilities made available to agencies when trying to attract individuals to the Federal service, or retain highly qualified professional, technical, or administrative personnel.

The final regulations describe the following: Loans Qualifying for Repayment, Employees Covered, Payment Limitations, Employee Service Requirements, and Selection Procedures.

Comments

OPM received comments from 15 agencies, four professional organizations, one labor union, and 14 individuals.

A few individuals opposed this regulation because they thought it was an unfair and inappropriate use of taxpayer monies. OPM disagrees and is moving forward with this regulation because we believe this incentive will benefit both agencies and employees. One individual thought this incentive was not fair to those individuals who never took out a student loan. Another individual thought it was inappropriate for the Federal government to be repaying loans when no incentive was being offered to those who managed to pay off their loans or stay out of debt in the first place. OPM disagrees, noting that Congress established this authority in statute.

Several agencies noted that non-General Schedule (GS) employees would be excluded from this incentive. Consequently, they asked that employees serving on other pay scales (including people serving in demonstration projects) be included in the final regulation. OPM did not incorporate this suggestion because the limitation to GS employees is specified in the authorizing statute.

Six agencies commented that the two level review process was overly burdensome and redundant. OPM agreed and streamlined this section by deleting the higher level review and approval portion of this section. Agencies must establish student loan repayment plans which include delegation of authority to review and approve offering student loan repayment benefits, but no further review process is needed.

Two agencies suggested that the final regulations clarify which employees would be eligible for the student loan repayment incentive. OPM did not adopt this suggestion because we will address specific examples in accompanying Questions and Answers guidance.

Three agencies suggested that OPM drop the ''case by case'' review requirement in the Criteria for Payment section. OPM adopted this suggestion. Several agencies complained that the ''factors to be considered'' portion of this section were overly restrictive and burdensome. OPM adopted this suggestion by deleting these considerations.

Twelve agencies suggested that OPM clarify the tax implications of this incentive and offer alternatives to help lessen the impact of a potential tax burden on recipients of this incentive. OPM adopted this suggestion and added language clarifying how agencies can make payments to ease the tax burden on recipients of loan repayment benefits. The final regulations specify that tax withholdings must be applied at the time any loan repayment is made. The final regulations also advise agencies that:

- In addition to lump sum payments, smaller, incremental payments can be made;
- Employees can write checks to the agency to cover their tax liability rather than have large withholdings deducted from their paychecks;
- Withholdings can be deducted from the amount of the loan repayment before it is issued; and
- The Internal Revenue Service should be consulted for specifics concerning the tax withholding implications of this incentive.

Several agencies suggested the final regulations shorten the three-year service requirement or give agencies the flexibility to prorate the service requirement when the full amount of the incentive is not being offered. OPM did not adopt this suggestion because the requirement is specified in statute. One agency suggested the final regulations clarify whether a new service agreement is needed when an agency extends or renews loan repayments. OPM adopted this suggestion with language stating a new service agreement is not needed in these situations but that agencies should say as much in their service agreements.

Several agencies suggested the final regulations require that individuals separated involuntarily for performance should have the same reimbursement obligation as employees who were separated involuntarily for misconduct. OPM adopted this suggestion. Also, several agencies suggested the final regulations specify that reimbursements to the Government can be made on a pro-rata basis. The regulations already provide for agencies to waive, in whole or in part, a right of recovery of an employee's debt.

Finally, one agency suggested the final regulations reduce the length of time agencies must keep records for payments made under this part from three years to two years. OPM did not adopt this suggestion because the 3-year requirement is consistent with the Governmentwide standard published by the National Archives and Records Administration for retaining records on other recruitment and retention incentives.

Executive Order 12866, Regulatory Review

This rule has been reviewed by the Office of Management and Budget in accordance with Executive Order 12866.

Regulatory Flexibility Act

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

List of Subjects in 5 CFR Part 537

Administrative practice and procedure, Government employees, Wages.

Office of Personnel Management.

Janice R. Lachance,

Director.

Accordingly, OPM is adding part 537 to title 5, Code of Federal Regulations, to read as follows:

PART 537—REPAYMENT OF STUDENT LOANS

Sec.

537.101 Purpose.
537.102 Definitions.
537.103 Agency loan repayment plans.
537.104 Employee eligibility.
537.105 Criteria for payment.
537.106 Procedures for making loan repayments.
537.107 Service agreements.
537.108 Loss of eligibility for loan repayment benefits.
537.109 Employee reimbursements to the Government.
537.110 Records.

Authority: 5 U.S.C. 5379.

§ 537.101 Purpose.

This part provides regulations to implement 5 U.S.C. 5379, which authorizes agencies to establish a program under which they may agree to repay (by direct payment on behalf of the employee) all or part of any outstanding federally insured student loan or loans previously taken out by a candidate to whom an offer of employment has been made, or a current employee of the agency, in order to recruit or retain highly qualified professional, technical or administrative personnel.

§ 537.102 Definitions.

In this part:

Agency has the same meaning as in 5 U.S.C. 4101(l) subparagraph (A), (B), (C), (D), or (E).

Employee has the meaning given that term in 5 U.S.C. 2105, except it does not include an employee occupying a position which —

(a) Is excepted from the competitive service because of its confidential, policy-determining, policy-making, or policy advocating character (*i.e.,* employees serving under Schedule C appointments); or

(b) Is not subject to the General Schedule established under 5 U.S.C. chapter 53, subchapter III.

Head of agency means the head of an Executive agency or an official who has been delegated the authority to act for the head of the agency in the matter concerned.

Service agreement means a written agreement between an agency and an employee under which the employee agrees to a specified period of employment with the agency of not less than 3 years, in return for payments toward a student loan previously taken out by the employee.

Student loan means—

(a) A loan made, insured, or guaranteed under parts B or E of title IV of the Higher Education Act of 1965; or

(b) A health education assistance loan made or insured under part C of title VII of the Public Health Service Act, or under part B of title VIII of that Act.

§ 537.103 Agency loan repayment plans.

(a) *Agency loan repayment plans.* Before repaying any student loans under this part, the head of an agency must establish a student loan repayment plan. This plan must include the following elements:

(1) The designation of officials with authority to review and approve offering student loan repayment benefits (agencies should use approval delegations which are similar to those used for other recruitment and relocation incentives);

(2) The situations when the loan repayment authority may be used;

(3) Criteria that must be met or considered in authorizing loan repayments, including criteria for determining the size and timing of a payment(s);

(4) Procedures for making loan payments;

(5) A system for selecting employees to receive repayment benefits that ensures fair and equitable treatment;

(6) Requirements for service agreements (including a basis for determining the length of service to be required if greater than the statutory minimum) and provisions for recovering any amount outstanding from an employee who fails to complete the period of employment established under a service agreement and for conditions when the agency decides to waive the employee's obligation to reimburse the agency for payments made under this part; and

(7) Documentation and recordkeeping requirements sufficient to allow reconstruction of the action taken in each case. (when an employee is considered for the repayment benefit.)

(b) [Reserved]

§ 537.104 Employee eligibility.

In accordance with the other provisions of this part and 5 U.S.C. 5379, an agency may authorize offering loan repayments benefits to recruit or retain—

(a) Temporary employees who are serving on appointments leading to conversion to term or permanent appointments; or

(b) Term employees with at least 3 years left on their appointment; or

(c) Permanent employees; or

(d) Employees serving on excepted appointments with conversion to term, career, or career conditional appointments (including, but not limited to, Career Intern or Presidential Management Intern appointments).

§ 537.105 Criteria for payment.

(a) *Written determination.* Loan repayments made under this part must be based on a written determination that, in the absence of offering loan repayment benefits, the agency would encounter difficulty either in filling the position with a highly qualified candidate, or retaining a highly qualified employee in that position. Agencies can decide for themselves who has the authority to make written determinations.

(b) *Determination for recruitment.* Each determination for recruitment purposes (including the amount to be paid) must be made before the employee actually enters on duty in the position for which he or she was recruited.

(c) *Determination for retention.* Payments authorized in order to retain an employee must be based upon a written determination that the high or unique qualifications of the employee or special need of the agency for the employee's services makes it essential to retain the employee, and that, in the absence of offering student loan repayment benefits, the employee would be likely to leave for employment outside the Federal service. This determination must be based on a written description of the extent to which the employee's departure would affect the agency's ability to carry out an activity or perform a function that is deemed essential to the agency's mission.

(d) *Selecting employees.* When selecting employees to receive loan repayment benefits, agencies must adhere to merit system principles and take into consideration the need to maintain a balanced workforce in which women and members of racial and ethnic minority groups are appropriately represented in Government service.

§ 537.106 Procedures for making loan repayments.

(a) *Conditions for payments.* Payments will be at the discretion of the agency and are subject to such terms, limitations, or conditions as may be

mutually agreed to in writing by the agency and employee. Payments may be applied only to the indebtedness outstanding at the time the agency and the employee enter into an agreement, and may not begin before the employee enters on duty with the agency. Student loan repayment benefits must be in addition to basic pay and any other form of compensation otherwise payable to the employee involved. Tax withholdings must be deducted or applied at the time any payment is made. Tax withholdings may not be spread out over time. Since these tax implications could create a financial hardship for the recipient of the repayment benefit, agencies can lessen the impact of tax withholdings on an employee's paycheck in one of the following ways:

(1) Agencies can make smaller payments at periodic intervals throughout the fiscal year rather than issue payments under this part in one lump sum;

(2) Employees can write a check to the paying agency to cover their tax liability rather than have the tax liability withheld from the employee's paycheck;

(3) Agencies can deduct the amount of taxes to be withheld from the loan repayment benefit before issuing payment to the holder of the loan.

(4) Agencies are strongly advised to consult the Internal Revenue Service for further details concerning these options as well as the tax withholding implications of payments under this part.

(b) *Loans to be repaid.* Before authorizing loan repayments, an agency must verify with the holder of the loan that the employee has an outstanding student loan that qualifies for repayment under this part. Agencies should verify remaining balances to ensure that loans are not overpaid. An agency may repay more than one loan as long as the loan repayments do not exceed the limits set forth in paragraph (c) of this section.

(c) *Size of payments.* In determining the size of the loan payments, an agency should take into consideration the employee's value to the agency, and how far in advance the agency can commit funds. If budgetary considerations are an issue, agencies have the discretion to determine the repayment benefit amount given to an employee each year. This type of arrangement must be included in the written service agreement with the employee. The amount paid by the agency is subject to all the following maximum limits:

(1) $6,000 per employee per calendar year; and

(2) A total of $40,000 per employee.

(d) *Employee responsibility.* The employee will be responsible for making loan payments on the portion of the loan(s) that continues to be the employee's responsibility. Payments under this part do not exempt an employee from his or her responsibility and/or liability for any loan(s) the individual has taken out. The employee will also be responsible for any income tax obligations resulting from the loan repayment benefit.

§ 537.107 Service agreements.

(a) Before any loan repayments may be made, an agency must require that the employee sign a written agreement to complete a specified period of employment with the agency and to reimburse the agency for loan repayment benefits, when required by § 537.109. This agreement may also specify any other employment conditions the agency considers to be appropriate, such as, but not limited to, the employee's position and the duties he or she is expected to perform, work schedule, or level of performance.

(b) The minimum period of employment to be established under a service agreement must be 3 years, regardless of the amount of loan repayment authorized. Agencies can state in their service agreements that increases or renewals of payments made under this part can be made without requiring the employee to enter into a new service agreement.

(c) A service agreement made under this part in no way constitutes a right, promise, or entitlement for continued employment or noncompetitive conversion to the competitive service. This language should be stated in the service agreement.

§ 537.108 Loss of eligibility for loan repayment benefits.

(a) An employee receiving loan repayment benefits from an agency will be ineligible for continued benefits from that agency if the employee:

(1) Separates from the agency; or

(2) Does not maintain an acceptable level of performance, as determined under standards and procedures prescribed by the head of the agency; or

(3) Violates any of the conditions of the service agreement.

(b) For the purpose of applying paragraph (a) of this section, in the case of an employee covered by an appraisal system established under part 430, subpart B, of this chapter, the employee's most recent rating of record must be at least level 3 (''Fully Successful'').

§ 537.109 Employee reimbursements to the Government.

(a) Except as provided in paragraph (d) of this section, an employee who fails to complete the period of employment established under a service agreement will be indebted to the Federal Government and must reimburse the paying agency for the amount of any student loan repayment benefits the employee received.

(b) Failure to complete the period of employment established under a service agreement occurs when the employee's service with the agency terminates before the employee completes the period of employment specified in the service agreement because:

(1) The employee is separated involuntarily on account of misconduct or performance; or

(2) The employee leaves the agency voluntarily.

(c) If an employee fails to reimburse the agency for the amount owed under paragraph (a) of this section, a sum equal to the amount outstanding must be recovered from the employee under the agency's regulations for collection by offset from an indebted Government employee under 5 U.S.C. 5514 and subpart K of part 550 of this chapter, or through the appropriate provisions governing debt collection if the individual is no longer a Federal employee.

(d) Paragraph (a) of this section does not apply when the employee fails to complete a period of employment established under a service agreement because:

(1) The employee is involuntarily separated for reasons other than misconduct or performance; or

(2) The employee leaves the agency voluntarily to enter into the service of any other agency, unless reimbursement to the paying agency is otherwise specified in the service agreement.

(e) The head of an agency may waive, in whole or in part, a right of recovery of an employee's debt if he or she determines that recovery would be against equity and good conscience or against the public interest.

(f) Any amount repaid, or recovered from, an employee under this section will be credited to the appropriation account from which the amount involved was originally paid. Any amount so credited will be merged with other sums in such account and will be available for the same purposes and period, and subject to the same limitations (if any), as the sums with which merged.

§ 537.110 Records

Each agency must keep a record of each determination made under this part and make such records available for review upon OPM's request. These records may be destroyed after 3 years or after OPM formally evaluates the program (whichever comes first).

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LIST OF PUBLIC LAWS

This completes the listing of public laws enacted during the second session of the 106th Congress. It may be used in conjunction with ''P L U S'' (Public Laws Update Service) on 202–523–6641. This list is also available online at http://www.nara.gov/fedreg.

The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at http://www.access.gpo.gov/nara/index.html. Some laws may not yet be available.

The list will resume when bills are enacted into public law during the next session of Congress. A cumulative list of Public Laws will be published in the **Federal Register** on Tuesday, January 16, 2001.

H.R. 5528/P.L. 106–568

Omnibus Indian Advancement Act (Dec. 27, 2000; 114 Stat. 2868)

H.R. 5640/P.L. 106–569

American Homeownership and Economic Opportunity Act of 2000 (Dec. 27, 2000; 114 Stat. 2944)

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Assistance for International Malaria Control Act (Dec. 27, 2000; 114 Stat. 3038)

H.R. 207/P.L. 106–571

Federal Physicians Comparability Allowance Amendments of 2000 (Dec. 28, 2000; 114 Stat. 3054)

H.R. 2816/P.L. 106–572

Computer Crime Enforcement Act (Dec. 28, 2000; 114 Stat. 3058)

H.R. 3594/P.L. 106–573

Installment Tax Correction Act of 2000 (Dec. 28, 2000; 114 Stat. 3061)

H.R. 4020/P.L. 106–574

To authorize the addition of land to Sequoia National Park, and for other purposes. (Dec. 28, 2000; 114 Stat. 3062)

H.R. 4656/P.L. 106–575

To authorize the Forest Service to convey certain lands in the Lake Tahoe Basin to the Washoe County School District for use as an elementary school site. (Dec. 28, 2000; 114 Stat. 3063)

S. 1761/P.L. 106–576

Lower Rio Grande Valley Water Resources Conservation and Improvement Act of 2000 (Dec. 28, 2000; 114 Stat. 3065)

S. 2749/P.L. 106–577

To establish the California Trail Interpretive Center in Elko, Nevada, to facilitate the interpretation of the history of development and use of trails in the settling of the western portion of the United States, and for other purposes. (Dec. 28, 2000; 114 Stat. 3068)

S. 2924/P.L. 106–578

Internet False Identification Prevention Act of 2000 (Dec. 28, 2000; 114 Stat. 3075)

S. 3181/P.L. 106–579

National Moment of Remembrance Act (Dec. 28, 2000; 114 Stat. 3078)

H.R. 1795/P.L. 106–580

National Institute of Biomedical Imaging and Bioengineering Establishment Act (Dec. 29, 2000; 114 Stat. 3088)

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